Living Well

Client Information Report

Please Print

Name ____ Date ___________

Address ______________________________________ Home Phone______________

City ______________________State _____ Zip _______ Cell phone ________________

Height _______________ Weight ______________ Birth Date _________________

Occupation __________________________ Referred By ______________________

What are your health concerns: ____

____

List medications: ____

Any surgeries: ____

Have you ever had or been diagnosed as having problems with any of the following:

__ Anemia __ Cancer __Diabetes __Prostate __ Heart __ Thyroid __ Skin/Acne __ Gallbladder

__ Fibromyalgia __ Kidneys __Fainting __ Menopause __ Ovaries __ Arthritis __ Headaches

__ High/Low Blood Pressure __PMS __Numbness in hands/feet __Hypoglycemia __Bleeding

__ Lungs __Asthma __Hiatus Hernia __Heartburn __Burping/Gas/Bloating __Edema __Weight

__Allergies __Throat __Ulcers __Breast __Spleen __Pancreas __Tumors

If there are other aspects of your medical history of which we should be aware, please indicate: __________

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How many bowl movements do you have per day? ________ If not daily, how often?______________

How much water do you drink per day? (in ounces) ______________

Other beverages you drink daily (Coffee, Tea, Juice, Soda, Alcohol etc.):______________________

Clients Signature ________________________________ Date __________________