CLIENT INFORMATION

Name:_____ Age: _____ Phone: _____

Address: _____ ZIP: _____

Email address: _____

Reason for this consult: _____

_____

[If cancer, what stage? ____ Have you had chemo? _____ radiation? _____]

Surgeries? _____

Prescription drugs? _____

_____

Nutritional Supplements you are taking: _____

_____

_____

Primary physician: _____

Other health care (Chiropractic, acupuncture, etc.): _____

_____

Spiritual preference (optional): _____

Comments: _____

_____

_____