Intake Date: _____
Referred By: _____

Client Information Form

Name:	**Cell Phone:**	**Home Phone:**
Business Phone:	**Date of Birth:**	
Address:		
Occupation:	**Employer:**	
Physician:	**Phone Number**:	
Emergency Contact Name:	**Phone Number:**	

How would you prefer to be contacted? Home Phone_____ Cell Phone _____ Cell Text Message _____ Email _____

Email address:

Please tell us your areas of interest, health and fitness goals, medical issues ongoing:, etc.

Interest in Nutrition Consultation with our Licensed, Registered Dietitian? Yes_____No _____

Other services you would like? _____

PAST MEDICAL HISTORY (include dates)

Significant Illnesses:

☐Cancer Type_____When_____ ☐Diabetes _____ ☐High Blood Pressure
☐Heart Disease_____
☐Rheumatic Fever ☐Thyroid Disease ☐Seizures ☐Hepatitis ☐Other: _____
☐Surgeries: _____
☐Significant Trauma (auto accidents, falls, etc.) _____
☐Allergies: (drugs, chemicals, foods) _____
☐Medicines taken within the last two months (includes vitamins, over-the-counter drugs, herbs, etc)

_____ _____ _____
_____ _____ _____
_____ _____ _____

HABITS

☐Cigarettes ☐Coffee ☐Tea ☐Cola ☐Alcohol ☐Drugs
☐Sweets ☐Other _____

FAMILY MEDICAL HISTORY

☐Diabetes ☐Cancer ☐High Blood Pressure ☐Heart Disease
☐Stroke ☐Seizures ☐Asthma ☐Allergies
☐Alcoholism ☐Other _____
☐Notes _____

GENERAL

☐Poor Appetite ☐Heavy Appetite ☐Poor Sleep ☐Heavy Sleep
☐Insomnia ☐Fatigue ☐Tremors ☐Vertigo
☐Cold Hands ☐Cold Feet ☐Cold Back ☐Cold Abdomen
☐Fevers ☐Chills ☐Night Sweats ☐Sweat Easily
☐Cravings ☐Localized Weakness ☐Poor Coordination ☐Recent change in appetite
☐Sudden energy drop at _____ time
☐Strong thirst (cold/hot drinks) _____
☐Bleed or bruise easily _____

HEAD, EYES, EARS, NOSE AND THROAT

☐Dizziness ☐Concussions ☐Migraines ☐Glasses
☐Contact Lenses ☐Eye pain/strain ☐Poor vision ☐Night blindness
☐Blurry vision ☐Ringing in ears ☐Poor hearing ☐Nose bleeds
☐Teeth problems ☐Sinus problems
Other Concerns _____

CARDIOVASCULAR

☐High blood pressure ☐Low blood pressure ☐Chest pain ☐Irregular heartbeat
☐Dizziness ☐Fainting ☐Cold Hands/Feet ☐Swelling in hands/feet
☐Blood clots ☐Phlebitis ☐Difficulty breathing
☐Other _____

RESPIRATORY

☐Chronic Cough ☐Asthma ☐Frequent Bronchitis
☐Frequent Pneumonia ☐Difficulty breathing when lying down
Other Concerns _____

GASTROINTESTINAL/URINARY

☐Frequent Nausea ☐Gas ☐Frequent Constipation
☐Frequent urination
Other Concerns _____

MUSCOLOSKELETAL

☐Neck pain ☐Back pain (where) _____ ☐Joint pain (where) _____
☐Other joint or bone problems? _____

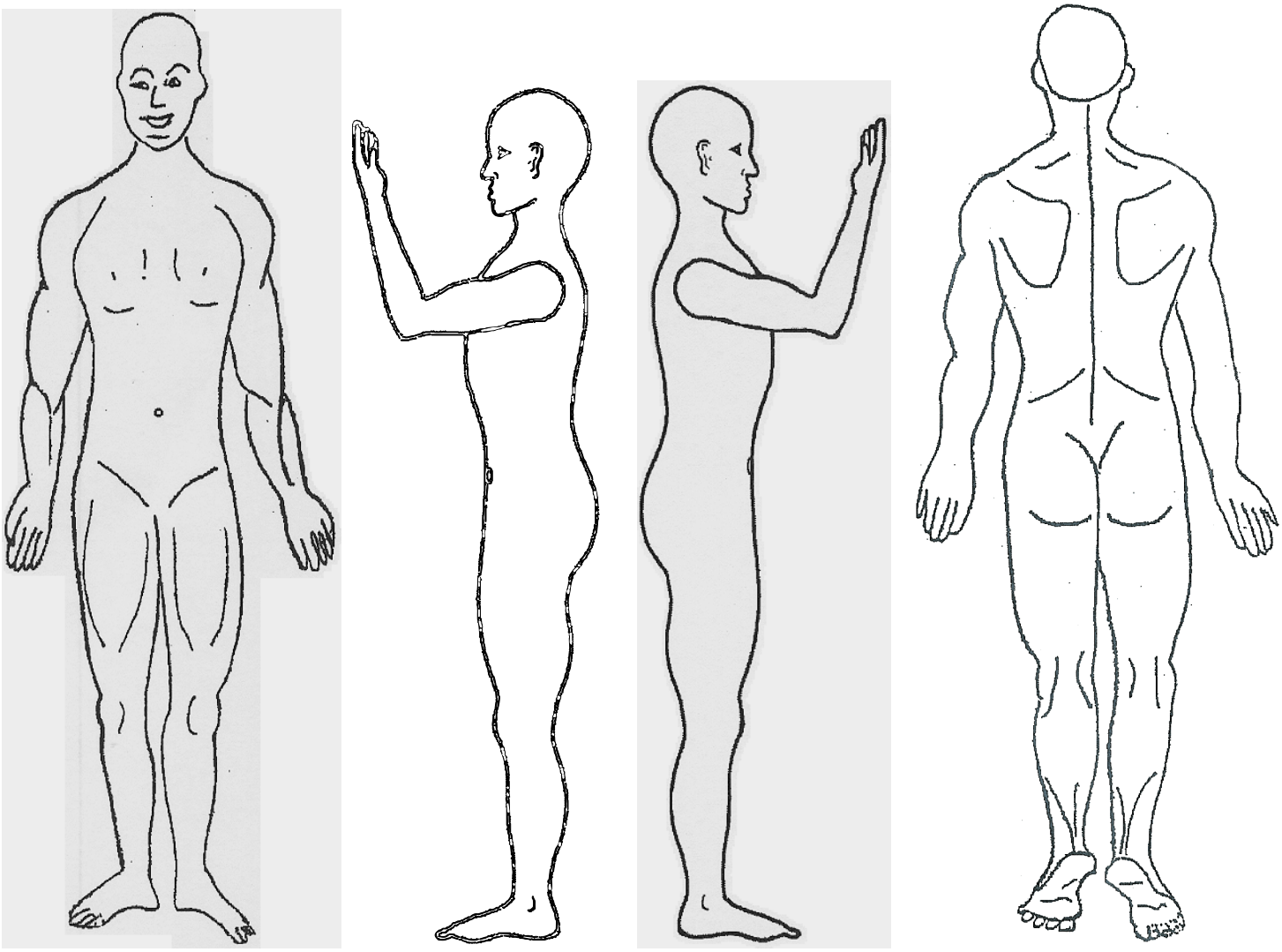
Note: This information will be maintained in a private file for each client.

_____ _____ _____
Client Signature Print Name Date

Parent/Guardian Signature, if applicable: _____

Pain /Scar/Trauma Chart

Name: _____ Date: _____



Directions:

All Trauma Areas. Please put an "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and Type of injury. Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 2009".)

Pain: Mark all locations of pain with a 'P'.