

# Nutrition and Healing Center

## NEW CLIENT INFORMATION FORM

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Please print clearly:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Shipping Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

e-mail address: \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Sex: M/F Height \_\_\_\_ Weight \_\_\_\_

Overall health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint \_\_\_\_\_

Other complaints or problems: (use separate sheet if needed) \_\_\_\_\_

Current medications/drugs being taken: (use separate sheet if needed) \_\_\_\_\_

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Nutritional supplements you are taking: \_\_\_\_\_

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

=====  
Office Use Only:

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Name: \_\_\_\_\_ Date \_\_\_\_\_

### HISTORY:

List any major illnesses (with approx. dates): \_\_\_\_\_  
\_\_\_\_\_

List any surgery or operations with approx. date: \_\_\_\_\_  
\_\_\_\_\_

Past Accidents or injuries: \_\_\_\_\_  
\_\_\_\_\_

Marital Status: S M D W Name of Spouse \_\_\_\_\_

Describe health of spouse: \_\_\_\_\_ Number of children if any \_\_\_\_

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other \_\_\_\_\_

Any household pets or other animals you or family members are in close contact with:  
\_\_\_\_\_

What can we do to make you happier? \_\_\_\_\_  
\_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE \_\_\_\_\_