CONFIDENTIAL CLIENT INFORMATION

Please Print

Name:_____ Date:_____

Street Address:_____

City / State / Zip:_____

Email Address:_____ Birthday:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Occupation:_____ Employer:_____

Emergency Contact - Name/Relationship/Phone:_____

Referred By:_____ Best Time / Day for Appointments:_____

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Are you currently under the care of a physician, chiropractor, physical therapist, psychotherapist or other health care practitioner? If Yes, Please Explain:_____

_____

Practitioner Name:_____Phone: _____

Please sign here for your consent to contact:_____

If You Have Had Surgery Within Two Years, Detail Please:_____

Please List *ALL* Allergies (food, medication, environmental, etc.):_____

Please List *ALL* Medications/Supplements Currently Being Taken:_____

Please Circle If You Have ANY of the Following:

Arteriosclerosis	Asthma	Blood Clots	Breast Implants
Carpal tunnel syndrome	Colitis	Contact Lenses	Diabetes
Easy Bruising	Epilepsy	Fainting	Fibromyalgia
Headaches	Hemophilia	Herniated Disc	Hepatitis
Herpes I or II	High/Low Blood Pressure		HIV/AIDS
Kidney disease	Lupus	Marfan syndrome	Multiple sclerosis
Muscular dystrophy	Osteoporosis	Phlebitis	Pregnancy
Sciatica	Scoliosis	Tendonitis	TMJ syndrome
Tuberculosis	Tumors	Varicose Veins	

Arthritis/location:_____ Bursitis/location:_____

Cancer/type: _____ Chronic Pain/location:_____

Heart Condition/type:_____ Infectious Condition/type:_____

Neck/Spine Injury/location:_____ Skin Disease/type/location:_____