Allergy & Health Solutions Center
Client Information Form

Name: _____ Date:_____

Address:_____City:_____ State:_____ Zip:_____

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

Email: _____ Occupation:_____

Age:_____ Birthdate:_____ How were you referred to us? _____

Why are you here? _____

Are you currently experiencing: ___Pain ___Illness ___Fatigue ___Weight Gain or Loss ___Cancer ___Other_____

When & Where did symptoms begin?_____

What steps have you taken for relief? _____

Have you consulted a Physician for medical diagnosis? ___No ___Yes, Name:_____ Date:_____

Specify diagnosis, treatment, recommendations prescribed:_____

_____

Please list all prescription & over-the-counter medicines that you take: _____

_____

Do you take: ___Vitamins ___Hormones ___Dietary Supplements ___Herbal Remedies ___Laxatives ___Antacids ___Fiber ___Other

If yes, please specify: _____

Are you allergic to: ___Medications ___Foods ___Airborne Irritants ___Skin Products ___Other LIST: _____

Have you ever had: ___Serious Accident ___Surgery ___Cosmetic Surgery LIST/DESCRIBE ALL: _____

_____

_____

How many hours per day do you normally sleep? _____ What type of exercise & how often: _____

Do you crave: ___Sweets ___Salty ___Breads ___Dairy ___Spicy ___Other_____

Daily water intake: ___<16 oz ___ 16-32 oz ___33-48 oz ___49-72 oz ___>72 oz

Frequency of bowel movements: ___Every Day ___4-6/wk ___2-4/wk ___ 1 or less/wk Have you ever given yourself an Enema? ___

Do you have: ___Eyeglasses ___Contact Lenses ___Dentures ___Prosthesis ___Internal Metal (i.e. Pacemaker, Bone Pins, Copper IUD, etc other than dental fillings) If yes, please specify _____

How would you rate your overall health: ___Excellent ___Good ___Fair ___Poor ___One foot in the grave

Please describe any physical conditions, ailments, limitations, or concerns the therapists should be aware of: _____

_____

_____

I have listed all known medical conditions and/or physical limitations, and I do hereby certify that the information I have provided is true and accurate. I understand that the information provided and any statements regarding my condition are confidential. Furthermore, I understand that I am solely reliable for any adverse condition or ailments predicted based upon or exacerbated by withholding medical information or failing to consult a physician for treatment. Signature: _____

Allergy & Health Solutions Center

Client Information Form

Please check ALL symptoms or conditions that apply, either currently or in the past.

GENERAL

___headaches
___insomnia
___loss of weight
___dizziness
___fainting spells
___history of seizures
___fatigue
___depression
___enlarged thyroid
___double/blurred vision
___diabetes
___loss of appetite
___night sweats
___hypoglycemia
___hiatal hernia
___unexplained weight loss in the last six months

CARDIOVASCULAR

___high blood pressure
___hardening of arteries
___angina (*chest pain*)
__poor circulation
___rapid heart beat
___irregular heart beat
___congestive heart failure
___swelling of ankles
___varicose veins
___heart attack
___stroke
___distended/bulging veins

MUSCLE/JOINT

___arthritis
___bursitis
___low back pain
___neck pain
___swollen joints
___injuries Where?
_____
_____
___*other pain Explain*
_____
_____
_____
_____

GASTRO-INTERNAL

___*colitis*
___constipation
___diarrhea
___Crohn's disease
___Ulcerative Colitis
___Diverticulitis
___gall bladder disease
___hemorrhoids
___fissures/fistulas
___rectal bleeding
___mucus in stool
___vomiting of blood
___candida
___liver trouble
___Cirrhosis
___Cancer

GENTO-URINARY

___kidney infection/stone
___painful urination
___*prostate trouble*
___kidney failure

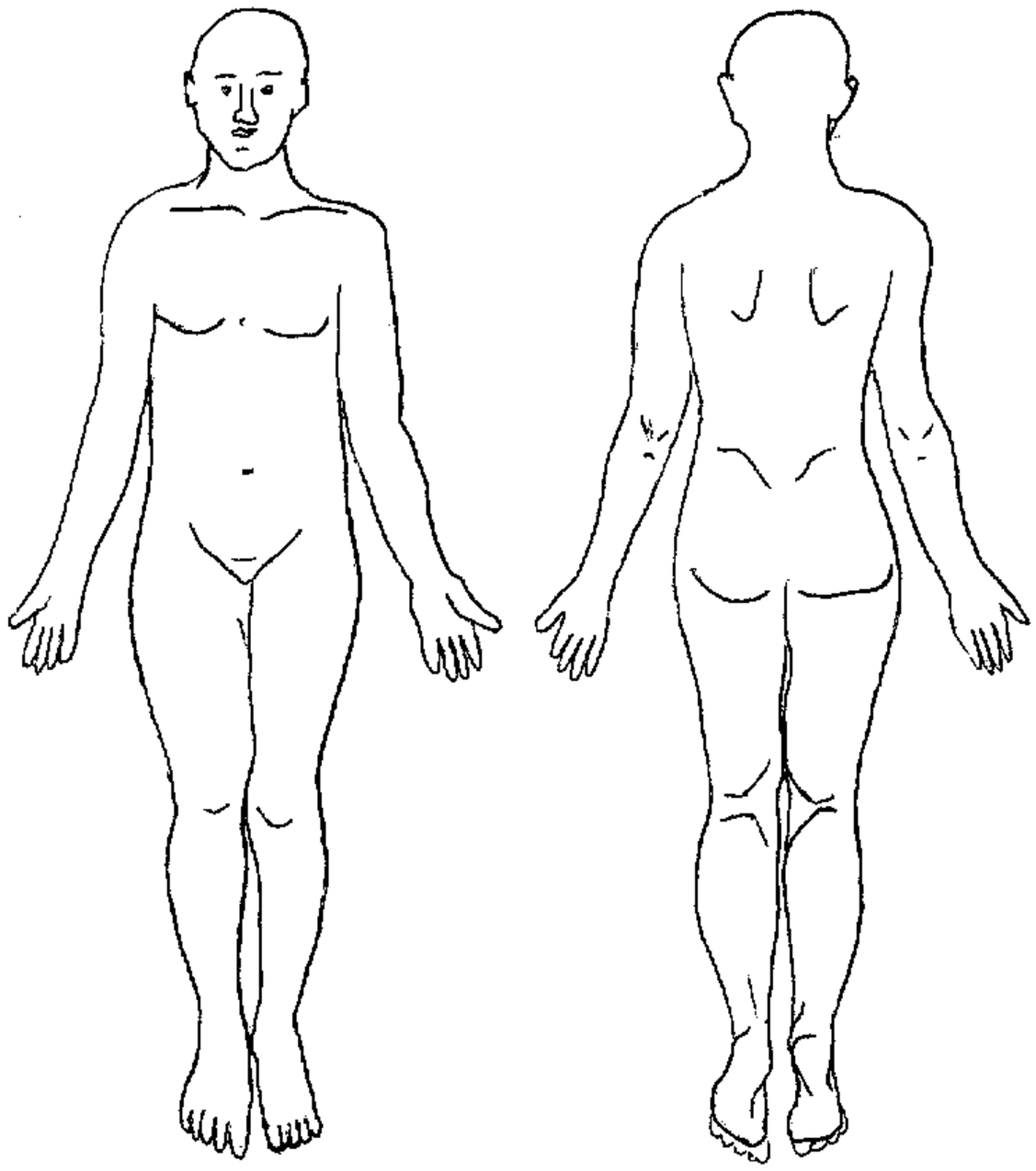
RESPIRATORY

___shortness of breath
___chronic cough
___emphysema
___bronchitis
___asthma/wheezing
___sinus/sinusitis

SKIN

___bruise easily
___dryness
___family history of colon cancer
___itching
___rash
___acne
___skin allergies
___*open wounds*
___skin eruptions
___other Explain_____
_____
_____

Please mark all locations where you are experiencing pain



NO CALL/NO SHOW POLICY

Our services can best be described as

low volume & high quality

We schedule our clients so that they receive maximum care with minimum waiting.
Each & every appointment space is important.
As a courtesy to all, we do not overbook.

We charge IN FULL for missed appointments.

This policy is necessary to maintain the high professional standards we practice & to keep our prices down.

I acknowledge that I have been informed of the full-service charge for missed appointments. I agree to honor & adhere to this policy.

_____

Client Signature Date