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**Confidential Client Record**

**PERSONAL**

**Name**: _______________________________________________ **Date**: ____________________

**Address**: _______________________________ **Phone**: _________________________________

_________________________________________________________________________________

***__EMAIL__: (A summary of this appointment will not be sent without an email.)

_________________________________________________________________________________

**Date of Birth**: ___________ **Male** / **Female** / **Transgender**

**Age**: _______ **Height**: _______ **Weight**: _______

**Marital Status**: __________________________________________
(single, married, divorced, wish you were divorced, not married, in long term relationship, other)

**Children** (Names & Ages):

**BLOOD TYPE**: _________ (if you know)

**MEDICAL HISTORY**

Have you ever been hospitalized? If so, explain…

Are you currently under a doctor's care for any illness/condition?

Do you suffer from anxiety, depression, bipolar? If so, how long?

*Allergies -

- *Foods*:
- *Medicine*:
- *Other*:

**WOMEN Only:**

1. Do you still get periods?
2. How often do you cycle?
3. Have you had a hysterectomy? Y / N When? _____________ Ovaries? ________
4. If menopausal, when did you menstruate last?
5. Last Pap Smear? _____________ Normal? ____________ Ever abnormal? __________
6. Last Mammogram?
7. Are you pregnant?
8. Who is your OB/GYN?

**MEN Only:**

1. Last physician visit: ____________________________________
2. Was PSA Level normal? (if applicable) _____________________
3. Any issue of impotence or erectile dysfunction? _____________
    a. How long?_____________

**MEDICATIONS:** (Men and Women)

| Name | Dose | Reason/Purpose | Duration of Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**SUPPLEMENTS:** (Men and Women)

| Name | Dose | Reason/Purpose | Duration of Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**FAMILY HISTORY**

Do you have a strong family history of any condition?

BOWEL HABITS

- How often do you have a bowel movement?
- Consistency? Hard / Soft / Watery / Pellets
- Do you strain?
- Color?
- Hemorrhoids?
- Rectal Bleeding? How frequent?
- Last Colonsocopy?
- PARASITES:
  a. Mucous?
  b. Dark Circles under eyes?
  c. Do you grind your teeth?

## GENERAL INFORMATION

Water Consumption per day: Bottle / Tap / Filtered / Other:

**Please list your health concerns in order of importance to you:** (This is most important!)

1. 4.
2. 5.
3. 6.

Your general state of health: Excellent / Good / Fair

Do you frequently use any of the following? List the type and frequency (if applicable):

Alcohol: Laxatives:
Antacids: Recreational drugs:
Caffeine: Tylenol/aspirin/advil:
Cigarettes: Sleeping pills:

Number of antibiotic treatments in the last 5 years?
Did you take antibiotics frequently as a child?
History of adverse reactions to immunizations: Y or N
Dietary restrictions (religious, vegetarian/vegan, etc):

SLEEP HABITS:

Bedtime?
Wake-up?
Check all that apply:

___ uninterrupted and deep
___ can't fall asleep-mind wanders
___ don't require much sleep
___ can't sleep much at all
___ fall asleep well, then pop-up between 1-2am
___ wake up too early
___ wake up very tired even though I slept well

<u>Typical Diet, very generally</u>:

Breakfast:
Snacks:
Lunch:
Beverages, type & amount:
Dinner:
Late Night:

What do you feel is your worst dietary habit?  Eating when I don't have time to prepare anything then I put anything in my mouth

Any history of eating disorder?

Is there any history of emotional, physical or sexual abuse?

Occupation:
Spiritual Beliefs/Religion:
Hobbies:
Do you exercise regularly?  Y or N
    Type:
    Frequency:

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc...) Please describe:

How would you describe the emotional climate of your home?

Has there been any major losses or traumatic events in the past few years?

Do you feel your life is stressful?     Why?