Complete Health
Wellness
Transformation

New Client Application and History

Name: _____Age: _____ Sex: M F DOB_____ Today's Date_____

Address: _____ City_____ State_____ Zip _____

Cell Phone: _____ Cell Phone Carrier: _____

Home Phone: _____ Work Phone: _____

Contact preference: Phone: _____☐Home ☐Work ☐Cell ☐Text Message
May we leave a voice mail? ☐Yes ☐No May we confirm appointments by text message? ☐Yes ☐No

Email address: _____ Receive e-health info? ☐ Yes ☐No

Employer:_____ Occupation: _____
Were you exposed to chemicals in your occupation? ☐ Yes ☐No Marital Status: ☐S ☐M ☐W ☐D ☐Engaged
Did your spouse or significant other attend session today? ☐Yes ☐No

How did you hear about us?_____

PRESENT COMPLAINTS

1. Main Problem: _____
2. In spite of the fact that you are not a doctor, you are in fact a person who knows more about your condition than anyone else. In your own words and in your own opinion, what do you think the real problem is?
_____ _____

3. What are the three things your health problems have caused you to miss the most?
a. _____ b. _____ c. _____

4. If you cannot find a solution to your problem, what do you think will happen? _____

6. What are your present symptoms: _____

_____

_____

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Due to your condition, have you lost time from (describe how much time and what tasks have been limited)?

Work: ☐Yes ☐No Describe: _____

Family: ☐Yes ☐No Describe: _____

Leisure Activities: ☐Yes ☐No Describe: _____

Medications/ Vitamins/ Skin Care Products/ Implants/ Pacemakers: _____

_____

_____

Diet: _____

_____

_____

Weight Currently: _____ **Ideal Weight: _____**

On a scale of 1-10 (1=least) (10=best), how important is your health? _____

I am requesting health or beauty related services and or products from you without having received from you any oral or written promise that these health or beauty services or products will have benefits for me in the treatment of any disease or condition I may have.

I understand that a 24 hour notice of cancellation is required or I will be charged the full cost of the treatment. I have read and understand the forgoing and voluntarily consent to the terms and conditions contained herein. Further, I understand that there is a charge for the consultation and a no refund policy in effect.

Patient's Signature: _____