

HEALTHY REVELATION CONSULTATION FORM

Presenter: Bill & Clara Bolin

Referer: _____

CLIENT INFORMATION

Name: _____ Date of Birth: ____/____/____

Phone Number: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____

Phone Number: _____ Relationship: _____

PRESENT HEALTH CONDITION

Please list the issues you are interested in correcting. How long have you noticed this problem?

_____	_____
_____	_____
_____	_____
_____	_____

Do you have cancer? If yes, list location, metastasis, and type of treatment used.

List any previous surgeries with the date they occurred.

List all allergies or sensitivities to food, medication, etc.

List any prescription drugs or nutritional supplements you are taking with dosage and frequency.

CONSENT & AGREEMENT

I hereby confirm that the information supplied is both true and accurate. This is a confidential record of your medical history. Copies of this record can only be released with your authorization.

Client Signature: _____ Date: _____