

CLIENT INFORMATION AND STATEMENT

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

HEALTH INFORMATION

1. Have you ever had or been diagnosed as having problems with any of the following.

- | | | | |
|------------------------------------|------------------------------------|----------------------------------|--|
| <input type="radio"/> Anemia | <input type="radio"/> Arthritis | <input type="radio"/> Cancer | <input type="radio"/> Liver |
| <input type="radio"/> Diabetes | <input type="radio"/> Ulcers | <input type="radio"/> Digestion | <input type="radio"/> Circulation |
| <input type="radio"/> Heart | <input type="radio"/> Kidneys | <input type="radio"/> Lungs | <input type="radio"/> Stomach |
| <input type="radio"/> Prostate | <input type="radio"/> Fainting | <input type="radio"/> Bleeding | <input type="radio"/> High bloodpressure |
| <input type="radio"/> Nerves | <input type="radio"/> Hypoglycemia | <input type="radio"/> PMS | <input type="radio"/> Alzheimer's |
| <input type="radio"/> Thyroid | <input type="radio"/> Ovaries | <input type="radio"/> Asthma | <input type="radio"/> Hay fever |
| <input type="radio"/> Skin | <input type="radio"/> Throat | <input type="radio"/> Epilepsy | <input type="radio"/> Hemorrhoids |
| <input type="radio"/> Gall bladder | <input type="radio"/> Breast | <input type="radio"/> Colon | <input type="radio"/> Constipation |
| <input type="radio"/> Tumors | <input type="radio"/> Bladder | <input type="radio"/> Spine/Back | <input type="radio"/> Parasites |
| <input type="radio"/> Spleen | <input type="radio"/> Pancreas | <input type="radio"/> Edema | <input type="radio"/> Weight |

2. Occupation: _____ Date of Birth: _____

3. Are you allergic to any medications or food? _____

4. Are you pregnant? Yes No if so, how many months? _____

5. Are you under a lot of stress? _____

6. Are you married, single, divorced or separated?

7. How many children do you have and are they living at home? _____

8. What is your relationship like with your spouse and children? _____

9. Please list any medications that you are taking: _____

10. Please tell us how you learned of our service: _____

CLIENT STATEMENT

I understand that I am meeting with you to learn about nutrition and better health practices and that I will be offered information about food and nutrition and herbs as a guide to general good health.

I fully understand that those who teach me about nutrition are not medical Doctors or practitioners and I am not here for medical- diagnostic purposes or treatment procedures.

The services performed by Ann Hallewell CNHP or others are restricted to the education of health through diet and nutrition for the achievement and maintenance of the best possible state of health.

Signature: _____ Date: _____

e-mail address for office use only: _____