CLIENT INFORMATION

Name:_____

Address:_____

_____

Phone Number:_____ **E-Mail:**_____

Height Feet: _____**Inches:**_____ **Weight:** _____ **Gender: m__f__**

Are you affiliated with Solex LLC? ____**Yes** ____**No**

Do you currently/or in the past, smoked or vaped? ____**Yes** ____**No**

Do you consume alcohol? ___**Yes** ___**No** **How much, how often**_____

_____

How many hours do you sleep at night?_____ **Difficulty sleeping?**_____

Use sleep aids?_____ **Name:**_____

How many ounces water do you drink daily?_____

Known food allergies? List:_____

What cooking oils do you use/eat?_____

Do you see a chiropractor/Acupuncturist/Massage Therapist/Spinal care?

_____

What medications are you currently on (if any)_____

_____

What supplements do you use?_____

_____

Have any surgeries in past 10 years?_____

Had any trauma/injuries?_____

Received vaccinations and boosters for Covid?_____

Do you get vaccinations for Flu?_____ **Pneumonia?**_____ **Shingles?**_____

Have you had shingles?_____**Were you vaccinated as a child**_____

LIST YOUR TOP 5 HEALTH CONCERNS:_____

_____

_____

_____

_____