CLIENT INFORMATION SHEET

Any information shared with us will be held in the strictest confidence. Date of initial learning session _____

Name:					Date:	
Address:						
City:		State:		Zip:		
Day phone:			Evening phone:			
Emergency contact person name & number:						
Height:	Weight:			A	Age:	
Marital status:	Occup		pation:			
Hobbies:						
Regular exercise:						
Medical history (please list all diseases, illnesses, surgeries, etc.):						
Emotional history:						
Family medical history (parents, brothers, sisters, aunts, uncles):						

Important people in your life (spouse, special friends, family, etc):

Typical day's	diet:	
Breakfast		
Lunch		
Dinner:		
Snacks:		
Diet History:		
Current presc	ription medications or any within the last 30 days:	
Current vitamin and/or herbal supplements:		
Have you taken herbal or other supplements in the past? If YES, what and were they effective?		

Current over the counter medications or other non-prescription medications or any within the last 30 days:

Identify daily habits and/or activities that may cause physical stress and/or emotional stress:

Currents ACTIVE health concerns:

Additional comments: