## **CLIENT INFORMATION SHEET**

Any information shared with us will be held in the strictest confidence.

Date of initial learning session \_\_\_\_\_\_

Name:				Date:		
Address:				I.		
City:		State:	Z	Zip:		
Day phone:		Evening phone:				
Email Address:			<u> </u>			
Emergency contact person name &	number:					
Height:	Weight: Ag		Age	e:		
Marital status:	Occupation:					
Hobbies:						
Regular exercise:						
Medical history (please list all diseases, illnesses, surgeries, etc.):						
Emotional history:						
Family medical history (parents, br	others, siste	rs, aun	ts, uncles):			

Important people in your life (spouse, special friends, family, etc):				
Typical day's diet:				
Breakfast				
Lunch				
Dinner:				
Snacks:				
Diet History:				
Current prescription medications or ar	ny within the last 30 days:			
- Current prescription incurcations of ar	y within the last 50 days.			
Current vitamin and/or herbal supplen	nents:			
Have you taken herbal or other supple	ements 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: