CLIENT HISTORY FORM

Name: _____ Gender: Male / Female DOB: _____

Address: _____

State: _____ Zip: _____ Country: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ e-mail: _____

Occupation: _____

Please complete all of the following. Use the backside of this form if you need additional space.

If you answer YES to any of the questions, please explain.

Have you ever experienced:

High Blood Pressure	YES	NO	_____
Heart Trouble	YES	NO	_____
Circulation Trouble	YES	NO	_____
Seizures	YES	NO	_____
Dizzy Spells	YES	NO	_____
Diabetes	YES	NO	_____
Migraines	YES	NO	_____
Other Illness	YES	NO	_____

Have you ever had surgery? YES NO
If YES, please list date, type of procedure and outcome:

_____

_____

_____

_____

_____

List any medications you are currently taking:

_____

_____

_____