Tap Into Your BEST

New Client Information Form

Please Print Clearly

Name_____ Date_____

Address_____ Apt. # _____

City_____ Postal Code _____

Home Phone (___)____-_____Cell (___)____-_____Work (___)____-_____

E-mail address (for monthly newsletter & announcements only)_____

REFERRRED BY(name please):_____

Occupation _____ Employer _____

Date of Birth _____ Age_____ Sex: M/F Height _____ Weight_____

Overall Health (circle one): Excellent / Good / Fair / Poor / other: _____

Chief Awareness (reason you are here):

_____

Previous treatments for this awareness:

_____

Other complaints or problems:

_____

Current medications / drugs being taken:

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name & date of last visit): _____

Nutritional supplements you are taking:

_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

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For office use only:

Practitioners Notes: (length / time)

HRT, Birth control pills -_____
History of refined carbs. -_____
History of sugar - _____
History of low calorie diet - _____
History of medication / drugs - _____
History of steroids - _____
History of non-organic - _____
History of x-rays or radiation - _____
History of lack of sleep (insomnia) - _____
History of chemical exposure - _____
History of genetic weakness - _____
History of stress events - _____

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HISTORY:

List any major illnesses (with approximate dates): _____

_____

List any surgery or operations with approximate date:

_____

_____

Past accidents or injuries:

_____

_____

Location of any & all scars:

_____

Marital Status: S M D W Name of Spouse_____

Describe health of Spouse: _____

Number of children: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M / F	_____
_____	____	M / F	_____
_____	____	M / F	_____

Any family history of serious illness (circle those that apply): Cancer / Diabetes / Heart / other

_____

Any household pets or other animals you or family members are in close contact with:

_____

Are you open to making appropriate lifestyle changes when recommended? Y / N

Other: _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of Disease."*

A vitamin is not a drug, NEITHER is Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patients' diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the benefit of Bio Energetic balancing.

I HAVE READ AND UNDERSTAND THE ABOVE

SIGNED: _____ DATE: _____