Name: _____ _ Date _____

Address: _____Date of Birth_____

Phone : _____(cell) _____(home/office)

e-mail: _____

Reason For Visit: _____

Age: _____ Height :_____ Weight: _____ Weight goal: _____

Please describe your current health status:

_____
_____
_____
_____
_____

Please list current over the counter & prescription medications:

_____
_____Drug Allergies?
_____

Please bring in your supplements, vitamins, minerals, amino acids & bio-identical hormones that you are currently taking. There are so many brands, quality and sources that we can only evaluate them as part of your program by actually seeing the container.

What are your hopes for your health in the near term and for the future? Please list any concerns.

_____
_____
_____
_____
_____

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Marital Status: _____

Children and ages: _____

What type of work do you do? _____

How do you sleep? *Well* *Trouble falling asleep* *Trouble staying asleep* *Insomnia*

How long has this been happening? _____ # Hours Sleep _____

Nights sweats? *Yes / No* Wake Tired? *Yes / No* Is your room completely dark? *Yes / No*

Do You.....

	No	Yes (how much/how often?)
Eat Refined Sugar & Carbs?		
Drink Alcohol?		
Smoke?		
Exercise?		

Please describe your health history including medical diagnosis, surgeries, medication usage and anything you consider significant:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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