

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.

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:



www.ebenezerwellness.com

214~415~0760