Medical History

Name: _____ Date: _____

Address: _____

Cell Phone: _____ Home Phone:_____

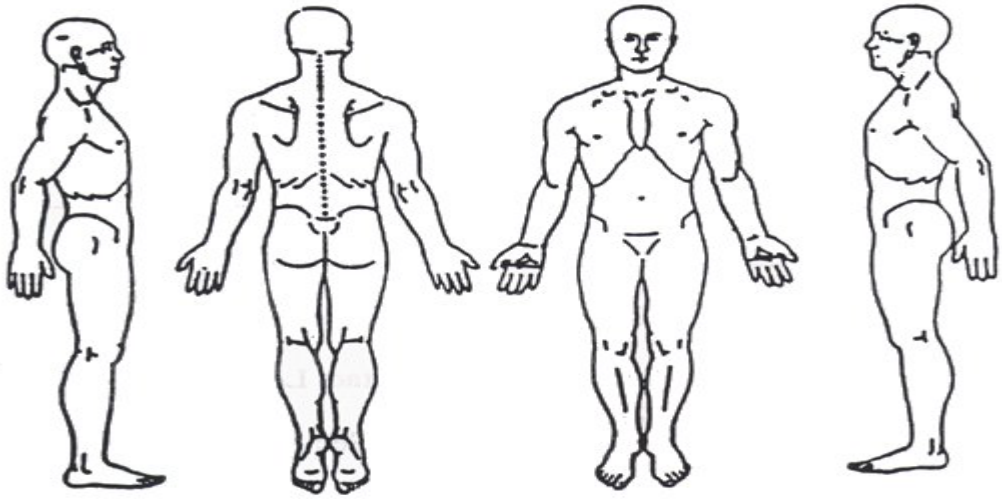
Email Address: _____Date of Birth:_____

Occupation: _____

How often do you exercise? _____What kind of exercise(s) _____

What supplements are you taking?_____

Please circle any problem areas below.



Right Left

Do you have any of the following? Please circle.

Asthma	Arthritis	Cancer	Digestive Issues	Heart Disease
High BP	Low BP	Diabetes	Pregnancy	Headaches/Migraines

Are you taking any medications? ☐ Yes ☐ No If yes, for what?_____

Injuries or surgeries? _____

Please note: For the benefit of other clients, I have a 24 hour cancellation policy.

Would you like to be included for my newsletter and other health related information? You can always opt out at a later date. Yes_____ No_____

Signature: _____