Clients Name:_____

Body Wholeness Restored
210-859-6600

Name:_____ Today's Date: _____
Home Phone: _____ Cell Phone: _____
E-mail Address: _____
Address: _____City: _____State._____ Zip:_____
Date of Birth: _____ Age: _____ SS#: _____
Sex: M_____F____ Height: _____Weight:_____ Referred by:_____
Marital Status: MSDW Number of Children: Boys_____ Girls _____

Employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: _____ Years at Job: _____

Name of Spouse: _____ Birth Date: _____

Emergency Contact Name_____ Relationship_____
Address_____ Phone:_____

Major comlplaints:_____
_____
_____

PAYMENT IS DUE AT THE TIME OF SERVICE

Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance. ***In addition there will be a $50 charge for cancellations under the 24 hour time frame.***

Clients Signature: _____ Date: _____

Spouse or Guardians Signature: _____ Date: _____

Consent to treatment

I _____ hereby consent, authorize and request _____
The treatment deemed advisable and necessary to my (my wards) condition in accordance with her expertise. I agree to hold her free and harmless from any claim, suits for damage or complications which may result from treatment.

Clients Signature _____ Print Name_____ Date_____

Witness Signature _____ Print Name _____ Date_____

Clients Name _____

Family History

Parents living: Father (age) _____ Mother (age) _____
Brothers: _____ Sisters: _____
Is there any family history of the following?
Diabetes _____ Asthma_____ Cancer_____ Mental Disease_____
Heart Disease_____ Lung Disease_____ Arthritis_____ Allergies_____
Any other (specify)_____

Personal History

Childhood Diseases: Measles_____ Mumps_____ Chickenpox_____
Unusual Childhood Diseases: _____
Do you smoke? _____ How many? _____ Drink coffee? _____ How much? _____
Do you drink alcohol? _____ How much? _____
Do you take any drugs? _____ List names_____
Do you take any Vitamins? ___ List names_____
Do you exercise? ____ Regular_____ Infrequently_____ Seldom_____
Are you pregnant now? _____ Last menstrual period_____
Hobbies if any _____

Past History:

List any significant injuries (slips, falls, auto accidents, etc.) and give dates:_____
_____

List any of your current health problems:_____
_____

List any past significant illness: _____
_____

List all surgeries (give dates) _____
_____
List any known allergies: _____
_____

List all abnormalities: _____
_____

Clients Name: _____

If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally, etc.: _____
_____
_____
Would you say you are under a lot of stress? _____ If yes, explain: _____
_____
_____
Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.: _____
_____

Women: Do you experience any pain or discomfort before, during, or after your menstrual cycle? Do you experience any pain or discomfort during the cycle week, regardless or whether you menstruate, are in menopause, skip your period periodically, or have had surgical removal of parts or all of the reproductive organs? During the cycle week are you grouchy? Irritable? Have crying spells? Feel uptight, more nervous or any other specific problems? _____
_____
_____
Chief complaints: _____
Describe present condition: _____
_____

Duration of present condition: _____
What do you believe caused this condition? _____
_____
When were you last seen by a physician? _____
For what purpose?_____
Your doctor's name: _____ Specialty: _____
Address: _____ City:_____ State: _____ Zip:_____
Phone number;_____ Significant diagnosis by your doctor: _____
_____
List all food and beverages taken more than three times per week: _____
_____-
_____