

NEW CLIENT INFORMATION PAGE

Name: _____ Date: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____

How you heard about Beverly: _____

Occupation: _____

Age: _____ Height & Weight _____

What symptom or issue bothers you the most? What treatments have you had?

What are your other 5 top concerns? Be specific.

How quickly do you expect to accomplish your health goals?

Do you need to closely watch your finances, or are you budgeted for optimal health?

Current medications, daily dosage and how long taken: _____

Current supplements (limit to 7 or 8 favorites please):

History major illnesses and approximate dates:

History surgeries and scars and approximate dates: _____

History accidents, blows and traumas:

Number of mercury (silver) fillings and/or root canals:

What is the thing you're most hoping I can help you with?

What is the biggest limiting factor in your life and happiness?

What do you do for fun or pleasure?