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New Client Form

Name ____ Date ________________________

Address ____

City ____ State _______ Zip __________________

Daytime Phone _____________________________ Evening Phone _________________________

Date of Birth ___________ Birth Time _____ City_______________ State_____ Country _______

Email ___________________________ Occupation ______________________________________

Emergency Contact ___________________________________ Phone _______________________

Primary Physician ____________________________________ Phone _______________________

Is present condition accident related? Yes ______ No ______

Describe present condition____

When was the onset? _________________________ What kind of treatments have been

sought?____

Does it effect
work?_______________Sleep?__________________Other?__________________________________

Please list any recent surgeries, hospitalizations, or accidents (include dates).

____

____

____

Do you have any communicable or infectious conditions? Yes _____ No _____

Injured areas or conditions: (examples: bruises, sprains, cuts, sores, rash, abnormal blood pressure, blood clots, cancer)

____

____

____

Are you pregnant? Yes _____ No _____ If yes, which trimester? ________________

Are you presently under a physicians care? Yes _____ No _____

List any medications you are currently taking:

___

___

___

List any Vitamins, Mineral, or Herbal Supplements you use:

___

___

___

What exercise do you do regularly?

___

___

List present therapies:

___

___

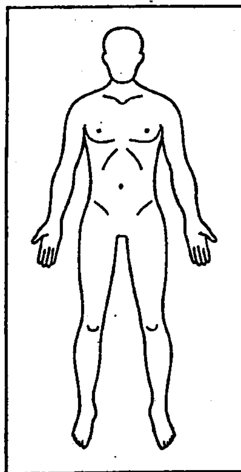
What would you identify as the 3 main stressors at the present time?

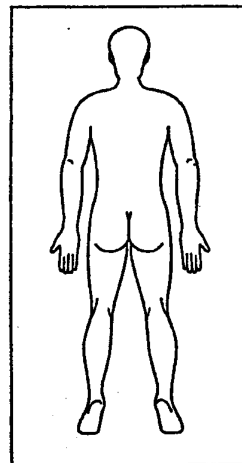
___

___

___

Please circle or mark areas of pain, or areas that need special attention on the body map below.





Are there problems other than the main problem?____

If yes, what are they?____

How would you prioritize the issues? 1.____

2.____

3.____

Frequently Eaten Foods:

Breakfast____

Lunch____

Dinner____

Snacks____

Fluid intake per day____

Stimulants, how much? (coffee, tea, tobacco, alcohol, etc)______________________________

Appetite? (small, normal, ravenous)__________________Thirst for hot or cold?_____________

Hours of sleep per night?______go to sleep @______wake @______do you feel rested?______

Bowel movements per day?_____Loose/Formed_____________Urination x day______________

Clear/yellow_______

Tend to be warm or cold easily?_________Tired or agitated?_______________

What is the most important improvement you would like to see in your life?_______________

What do you see being your biggest obstacle in obtaining this?_____________________________

____

Whom may I thank for your referral? ____

Please sign and date:

I understand that Linda Flach Corl, B.S., HHP does not diagnose or treat illness. I take full responsibility for seeking appropriate medical assistance when I feel it is indicated for my well-being.

____ Date _________________

Thank you for your time in providing this information.