Confidential Client Health Survey

Client Name (print)_____ Date_____
Date of Birth_____ Occupation_____

Describe What You Would Like to Address Today _____
_____
_____

List Any Emotional Issues You Are Experiencing Today _____
_____
_____

Have You Had A Stroke Within The Past Month_____
Have You Had Radiation Treatment In The Past 48 Hours_____
Do You Have Any Contagious Skin Diseases_____
Do You Have Varicose Veins, Open Sores, Bruises or Ulcers_____
Are You or Could You Be Pregnant _____
Where Are You in Your Menstrual Cycle_____
What (if any) Food or Taste Cravings Are You Experiencing _____

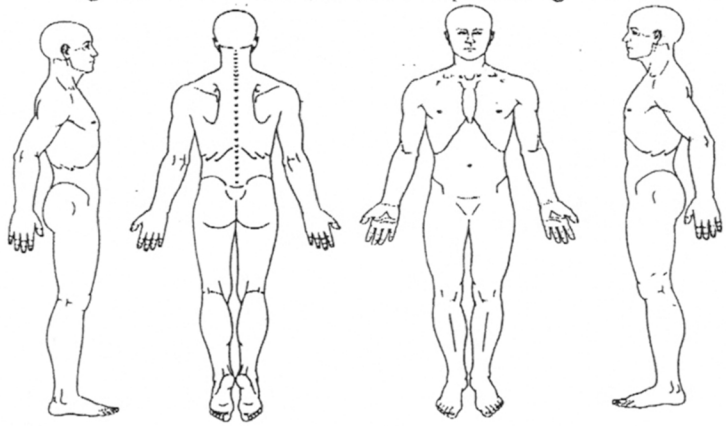
List Surgeries and Broken Bones You Have Had (most recent first)

_____ _____ _____
_____ _____ _____

List Conditions You Are Under A Doctor's Care For and Prescriptions Taking For Them

_____
_____
_____
_____

Indicate On Diagrams Below Where You Are Experiencing Pain or Other Symptoms



Client Signature _____

Comments: