

CONFIDENTIAL CLIENT INFORMATION SURVEY

NAME _____ DATE OF VISIT _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE _____
DATE OF BIRTH _____ AGE _____ WEIGHT _____

REASON FOR VISIT _____

LIST ANY ALLERGIES _____

DO YOU HAVE HIGH BLOOD PRESSURE? _____

DO YOU HAVE EPILEPSY? _____

DO YOU HAVE A HISTORY OF HEART TROUBLE? _____

DO YOU HAVE RESPIRATORY PROBLEMS? _____

ARE YOU PREGNANT? _____

LIST ANY CHRONIC HEALTH PROBLEMS:

SURGERIES: _____

CONTACTS IN EYES? yes _____ no _____

ARE YOU CURRENTLY TAKING MEDICATION? _____

PLEASE LIST ANY MEDICATIONS:

VITAMINS/HERBS: _____

HOW WOULD YOU RATE YOUR HEALTH? (Place an X)

excellent __ good __ fair __ poor ____ WHY?

PLEASE LIST ANY FEARS OR PHOBIAS:

I understand that Annette Kohn-Lau shares holistic health information for
EDUCATIONAL PURPOSES ONLY. It is not our desire to replace your regular
family physician or diagnose or prescribe any course of treatment. Thank you!

Signed: _____
(Your Name)