# 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)