



CLIENT INFORMATION SHEET

PERSONAL INFORMATION:

NAME _____

HOME PHONE _____ WORK PHONE _____

ADDRESS _____

EMAIL ADDRESS _____ ADD TO EMAILING LIST _____

BIRTH DATE _____ AGE _____ GENDER _____

HEIGHT _____ WEIGHT _____

HOW DID YOU HEAR ABOUT OPTIMUM HEALTH? _____

Are you affiliated with the FDA, or any other governmental agency. _____

Which one? _____

YOUR CONCERNS:

What brings you to Optimum Health? _____

(Indicate your most important concerns with the numbers 1 to 5 where 1 is the most important.)

<input type="text"/> Eating Habits	<input type="text"/> Remaining Youthful	<input type="text"/> Current Diseases
<input type="text"/> Skin Problems	<input type="text"/> Energy Level	Other <input type="text"/>
<input type="text"/> Overall Beauty	<input type="text"/> Weight management	Other <input type="text"/>
<input type="text"/> Hair Problems	<input type="text"/> Possible Diseases	Other <input type="text"/>

YOUR BODY:

SMOKING

Do you smoke currently? If yes, how long have you smoked? How many packs a day?
Did you quit smoking? If yes, how long did you smoke? How many packs a day?

DIET

What foods describe your eating habits?

Vegetarian Gluten Free No Dairy

Other/Comment

PROTIEN _____

How many colds do you get a year?

Do you have Allergies?

Do you have brittle fingernails? Brittle, breaking hair

Have you ever had acne? If yes, when?

Do you have mouth ulcers?

Do you have thick skin? Eczema Dermatitis

Are you having trouble focusing?

Do you have low blood sugar? Fever blisters Asthma

Do you have excessive cellulite? Enlarged facial pores Wrinkles

Do you forget things often?

If yes, how often? Several times a day Daily Weekly Rarely

B COMPLEX _____

How often are you depressed?

Irritable?

Suicidal?

Do you have ridges on your fingernails?

Enlarged tongue?

Night sweats

How often do you get tired?

Crave sugary foods?

How often do you have mood changes?

Never

Hourly?

Daily?

Weekly?

Monthly?

Yearly?

ENZYMES _____

Do you have ridges on your fingernails?

Do you have gas with meals?

INTESTINAL FLORA _____

Do you have gas with meals

Heartburn?

Sour stomach after meals?

Do you have acid reflux?

Constipation?

Diarrhea?

Have you had a recurrent vaginal yeast infection?

Do you have bad morning breath?

How many bowel movements do you have each day?

Antibiotics?

Are you lactose intolerant?

When you pass gas, does it stink

ELIMINATION _____

Which describe your stool?

How many bowel movements do you have each day?

How often do you have constipation? Diarrhea? Hemorrhoids

How would you best describe your stool? (Check all that apply.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Dark brown | <input type="checkbox"/> Little balls | <input type="checkbox"/> The consistency of applesauce |
| <input type="checkbox"/> Sandy colored | <input type="checkbox"/> Narrow pencil size | <input type="checkbox"/> Very watery |
| <input type="checkbox"/> Most sink | <input type="checkbox"/> Sausage size | <input type="checkbox"/> The consistency of oatmeal |
| <input type="checkbox"/> Most float | <input type="checkbox"/> Hot dog size | <input type="checkbox"/> Bright red in some stools |
| <input type="checkbox"/> Some float and some sink | | |

VITAMIN C _____

Do you bruise easily?

Do you have varicose veins? Keloids Hangnails Mini strokes

VITAMIN E _____

Do you have hot flashes? Cold feet and hands Deep bone pain

Do your lips chap?

If so, how often? Daily? Weekly? Monthly? Yearly?

CALCIUM _____

Do you grind your teeth?

Do you have trouble falling to sleep?

Sleep lightly?

Do you wake up all through the night?

Wake up tired in the morning?

Do you have numbness in your fingers or toes/feet during the day?

At night?

Do you have any of the following? (Check all that apply.)

Receding gums

TMJ pain

Heart palpitations

Menstrual cramps

Muscle cramps

Muscle tension across your shoulders

TOXICITY _____

Have you ever had metal colored fillings?

How many?

For how long?

Do you have swollen ankles or feet?

Arthritis

Do you have dark spider or varicose veins?

How often are you tired?

Too tired to make it across the room

Take naps

How often do you get a headache?

Have you ever drunk well water?

If yes, when and how long?

Have you worked in an orchard?

If yes, when and how long?

Have you worked with metal?

If yes, explain.

If yes, when and how long?

MISCELANEOUS

How many times a week do you work into a sweat for 20 or more minutes?

What is your blood type?

Do you have swollen ankles or feet?

Do you have high blood pressure?

Do you have high cholesterol?

How often do you take laxatives

Do you have to get up and pee more than twice a night?

Have you have any sudden hair loss? If yes, describe.

How stressful do you consider your life?

Not stressful Rarely stressful Sometimes stressful Usually stressful Always stressful

Have you had decrease or lack of libido? If yes, describe.

Do you have hot flashes? If so, how often?

CHIROPRACTIC

Have you had any recent falls?

Do you regularly have headaches? Sinus problems Incontenance

Do you have pain in any of the following areas? (Check all that apply.)

Hip(s)

Leg(s)

Joint(s)

Neck

CHECK ALL CLINICAL DIAGNOSIS:

- A.L.S.
- Alzheimer's
- Anemia
- Angina
- Arteriosclerosis
- Arthritis
- Bradycardia
- Bursitis
- Candidacies, systemic
- Candidacies, vaginal
- Cancer, type _____
- Cataracts
- Colitis
- Crohn's disease
- Cystic fibrosis
- Dementia
- Diabetes
- Disc degeneration
- Diverticulosis
- Dyslexia
- Emphysema
- Endometriosis
- Epilepsy

- Frequent urination
- Fibrocystic disease
- Fibromyalgia
- Gall stones
- Gastritis
- Glaucoma
- Gout
- Headaches
- hepatitis
- Hypercholesterolemia
- hyperadrenia
- Hyperlipidemia
- Hypertension
- Hyperthyroidism
- Hypoadrenia
- Hypothyroidism
- Liver dysfunction
- Liver cancer
- Lupus
- Migraines
- Hyperglycemia
- Hypoglycemia
- Infections (bacterial)
- Irritable bowel syndrome

- Mononucleosis
- Multiple sclerosis
- Muscular dystrophy
- Osteoporosis
- Ovarian cysts
- Paget's disease
- Parkinson's
- Pms
- Renal disease
- Scleroderma
- Stones, calcium oxalate
- Stones, phosphate stones
- Stroke
- Tachycardia
- Tourette's syndrome
- Tumors, benign breast
- Tumors, malignant breast
- Ulcers – gastric
- Ulcers – duodenal
- Viruses
- Hemachromatosis

Bladder disturbances Explain _____

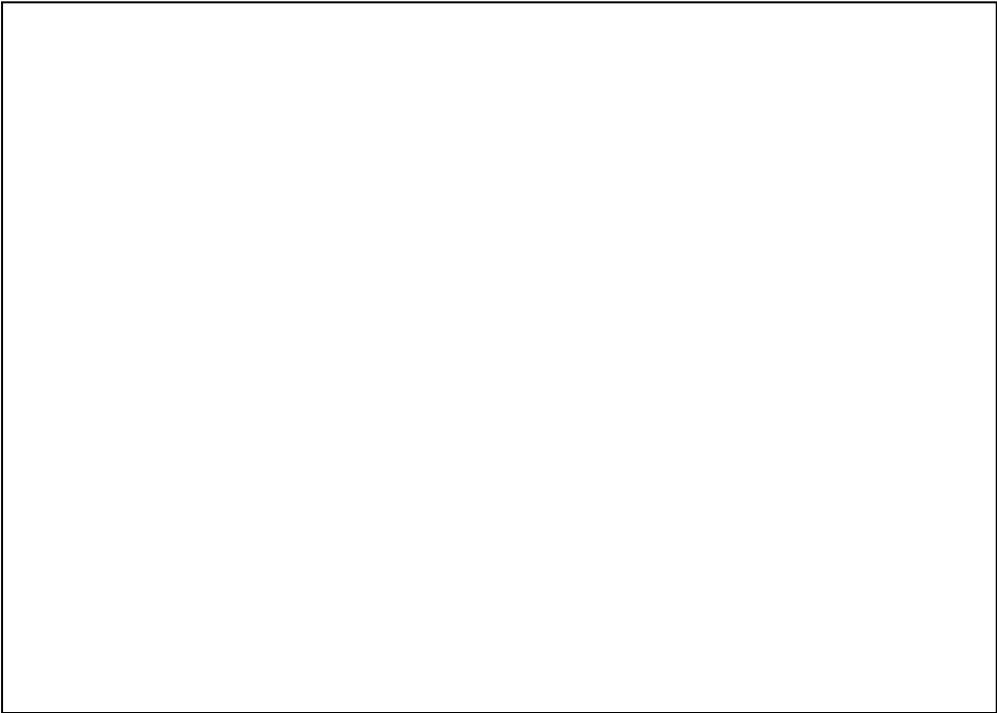
FAMILY HISTORY:

	Mother	Mother's Mother	Mother's Father	Father	Father's Mother	Father's Father
Cancer						
Strokes						
Hypertension						
Depression						
Heart Attacks						
Diabetes						
Suicide						
Other:_____						
Other:_____						

ARE YOU AFFILIATED WITH THE FDA, FTC OR ANY OTHER GOVERNMENTAL AGENCY?_____

*******STOP*******

Passport



Updated Passport

