**Are you wearing contact lenses?** **[ ] yes [ ] no**

**For Women:**
Are you menstruating today? [ ] yes [ ] no

Is there any possibility that you are pregnant? [ ] yes [ ] no

Are you post-menopausal? [ ] yes [ ] no

**Please list your supplements:**
Vitamins:

Minerals:

Antioxidants:

**What is your daily intake of...?**
Pure water _____ 8-oz glass
Fruit juice _____ 8-oz glass
Soft drinks _____ 8-oz glass
Tea/coffee _____ 8-oz glass
Alcohol _____ 5-oz glass

**Briefly describe your diet:**

**Other Health/Life Style Facts:**

Are your bowel movements: ____ times/day ____ times/week

How often do you exercise? [ ] daily [ ] weekly [ ] occasionally [ ] never

What types of exercise do you engage in?

Rate the level of stress in your life right now on a scale of 1-10 (1=none 10= 100%) _____

## CLIENT INFORMATION (Confidential)

**Name:** **Date:**

**Address:**

**Daytime phone:** **Evening phone:** **E-Mail:**

**Emergency contact:**

**Date of Birth:**

**How did we hear from you? Who referred you?**

**Briefly describe your health concern(s).**

**Please list previous/other illnesses, injuries, surgeries and approximate dates:**

**Please list any chronic condition, e.g., headaches, thyroid problems, heart or kidney condition, indigestion, insomnia, infections and any medication(s) you are currently taking for each one:**

**Do you have any burns, fresh scars, bruises, eczema, or moles?** **[ ] yes [ ] no**
**If yes which and where are they? How long have you had them?**