Lipton Natural Health Improvement Center

New Client Information Form

Name:_____ Date: _____

Address:_____ Apt.#:_____

City/State/Zip:_____

Home Phone:_____Cell Phone:_____

Cell Phone Provider:_____

Would you like to receive text appointment reminders? _____

If yes, choose one: 1 day prior to appointment 1 hour prior to appointment

E-mail Address:_____

Date of Birth:_____ Age: _____ Gender:_____ Height:_____

Current Weight:_____ Would you like your weight to be different?_____

Occupation:_____ Employer:_____

Relationship Status:_____

Referred by:_____

Please list any children along with their name, age, and any physical conditions or concerns:

_____

_____

Describe the symptoms you are currently experiencing (Reason you are here)?

_____

_____

_____

What can we do to make you happier? _____

_____

Previous treatments for symptoms:_____

_____

_____

Are you currently under a practitioner's care for a specific health issue? If so, what treatments are you currently undergoing?_____

_____

Current medications/nutritional supplements being taken:_____

_____

_____

Do you have any known allergies to medications or herbs? Please list:_____

_____

Have you received the COVID 19 shot? Y / N

Type Received: _____

Dates Received: 1st shot _____2nd Shot_____

Reactions noted: _____

List any surgeries, accidents, injuries or childhood illnesses and date and/or scars:

_____

_____

Do you smoke, drink coffee, soda, or alcohol? If yes, indicate how much per day or week.

Cigarettes:_____Coffee:_____Alcohol:_____ Soda:_____Water_____

Do you sleep well?_____ Wake up during the night?_____ Difficulty falling asleep?_____

How do you feel when you wake up?_____

Describe any regular exercise: _____

Please list any household pets or other animals you or your family members come in close contact with:_____

Do you crave sugar?_____ Crave salt? _____ Excessive Hunger?_____ Poor appetite?_____

Do you feel: Tired / Bloated / Gassy after meals? (Circle ones that apply)

Do you experience heart burn? When does it occur and how often? _____

Do you have Constipation or Diarrhea regularly? How often? _____

Family Health History

Please indicate if there is family history of serious illness and their relation to you.

Diabetes:_____ Kidney Disease:_____

Heart Disease:_____ Arthritis:_____

Cancer(indicate type):_____

Asthma:_____ Gallbladder Disease:_____

Stomach/Intestinal Disorders:_____

Mother: Age:_____ Died from?:_____

Father: Age:_____ Died from?:_____

Dietary Intake for 2 days before appointment:

Day 1	**Day 2**
Breakfast:	Breakfast:
Lunch:	Lunch:
Dinner:	Dinner:
Snacks:	Snacks:

Women only:

Age of your first period:_____ Are your periods regular?_____

Describe frequency and duration:_____

Do you experience PMS? Describe severity and symptoms: _____

_____

Are you peri-menopausal? _____ When did this change occur?_____

Are you menopausal?_____ When was your last period?_____

List your symptoms of peri/menopause:_____

_____

Number of pregnancies:_____

How many children have you delivered and how were they born (vaginally or by cesarean)?:

_____

Were there complications associated with these births? Please explain:_____

_____

Did you have an episiotomy scar or experience tearing? Please describe:_____

_____

Please list any miscarriages or abortions:_____