Client Chart Therapist:____________________

Name	Date:	Fax:
Address	City	Email
Home Phone	Postal Code	
Occupation	Employer	
D.O.B.	Family Doctor	
Referred by	Reason for Appointment	
Are you under medical treatment now?		

List current medications, herbs & supplements	List allergies: Drugs, Plants or other

Please check any of the symptoms or physical problems listed below that you experience:

Allergies	Diabetes	Epilepsy	Arthritis	Scoliosis
Headaches	Asthma	Dizziness	Weakness	Indigestion
Sciatic	High/Low BP	Hearing	Insomnia	Vision
Cardiovascular	Vascular	Memory	Fatigue	Numbness
Back Pain	Reproductive	Sleep	Sinus	Migraines
Alcohol	Chronic Fatigue	Candida	Ulcers	Hepatitis
Cancer	Thrombosis	Bronchitis	Warts	Fungal Infections

Are you currently pregnant or trying? Have you been tested for HIV? Positive ?

Do you have any skin conditions? Have you had a recent injury?

Are you in severe pain at this time? Have you taken pain medication today?

Current Health	Poor	Good	Excellent
Current Stress Level:	Low	Moderate	High

DISCLAIMER: As a professional therapist, I do not make any claim of replacing any holistic or medical therapy. This therapy is of a complimentary nature only, rather than a curative treatment in

itself. I adhere to the standards of practice and code of ethics set out by our respective governing bodies. I accept the responsibility of knowing what treatment that I want and have agreed to with this therapist.

Client's Signature of Consent for Treatment:
____