New Client Registration

Date : _____

Name : _____

Address : _____

Mobile : _____

E-mail : _____

D.O.B. : _____ Age : _____ Sex : Male / Female

Single / Married / Divorced / Widowed

Occupation:

Main complaints that bring you here today:

Previous diseases, STD's-
Please also list conventional medicine and homeopathic prescriptions administered for those:

Family history:

	Infectious Diseases/Health Conditions/Causes of Death
Mother	
Father	
Brothers, sisters	
Maternal Grand- & Great-Grandparents	
Maternal Aunts & Uncles	
Paternal Grand- & Great-Grandparents	
Paternal Aunts & Uncles	

Did you have any reactions to immunizations?
If yes, describe reaction, your age, and which immunization

Temperature:
Do you run hot or cold?

How is your sleep:

Appetite/desire:
All foods being created equal, what is your favorite dish and preferred drink?

Your Habits:

Your habits	How much?	Any reactions?
Smoking		
Alcohol		
Tea		
Coffee		
Sleeping Pills		
Any other		

Anything else you would like to share with me: