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:

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

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	

<u>Did you have any reactions to immunizations?</u>
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) de la		
Smoking Alcohol Tea Coffee Sleeping Pills	Your habits	How much?	Any reactions?
Alcohol Tea Coffee Sleeping Pills			
Alcohol Tea Coffee Sleeping Pills			
Alcohol Tea Coffee Sleeping Pills	Smoking		
Tea Coffee Sleeping Pills			
Tea Coffee Sleeping Pills			
Tea Coffee Sleeping Pills	Alcohol		
Coffee Sleeping Pills			
Coffee Sleeping Pills			
Coffee Sleeping Pills	Tea		
Sleeping Pills	1.00		
Sleeping Pills			
Sleeping Pills	Coffee		
Pills	Conce		
Pills			
Pills	Sleening		
Any other	Pills		
	Any other		
7.1.7 56.16.	Ally other		

Anything else you would like to share with me: