

Confidential Client Health Survey

Client Name (print) _____ Date _____
Date of Birth _____ Occupation _____

Describe What You Would Like to Address Today _____

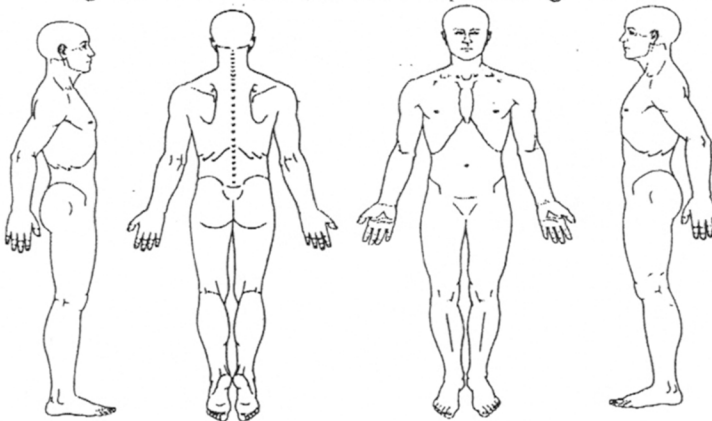
List Any Emotional Issues You Are Experiencing Today _____

Have You Had A Stroke Within The Past Month _____
Have You Had Radiation Treatment In The Past 48 Hours _____
Do You Have Any Contagious Skin Diseases _____
Do You Have Varicose Veins, Open Sores, Bruises or Ulcers _____
Are You or Could You Be Pregnant _____
Where Are You in Your Menstrual Cycle _____
What (if any) Food or Taste Cravings Are You Experiencing _____

List Surgeries and Broken Bones You Have Had (most recent first)

List Conditions You Are Under A Doctor's Care For and Prescriptions Taking For Them

Indicate On Diagrams Below Where You Are Experiencing Pain or Other Symptoms



Client Signature _____

Comments: