Sarasota Healing Arts
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New Client Information

Name:______________________________ Birthdate:__________ Today's date:________

Address:____
Street City State Zip Code

Telephone: (H)____________________(Cell)__________________ E-mail_____________

Marital Status: Single Married Divorced Separated Widowed Number of Children:______

Occupation:____________________ Referred by:______________________________

Major Complaints in order of importance to you

Complaint	Since	Cause

What medications are you currently taking?

Medication	Dose	Since	Adverse Effects

Supplements

What other treatment plans are you currently following?

Treatment	Since	Results

Which of the following conditions have you had? (please circle all that apply)

Abscesses	Cold sores	Genital herpes	Menstrual problems	Respiratory disease	Thyroid condition
Acne	Fatigue	Goiter	Miscarriage	Root canal	Tonsillitis
Alcoholism	Depression	Gout	Mononucleosis	Scarlet fever	Tropical disease
Allergies	Diabetes	Hay fever	Mood problems	Seizures	Tuberculosis
Anemia	Dizziness	Headaches	Mumps	Septicemia	Uterine fibroid
Asthma	Digestive problems	Heart disease	Parasites	Sexual abuse	Vaginitis
Athlete's foot	Ear infections	Hepatitis	Pelvic inflammatory disease	Sinusitis	Venereal warts
Back pain	Endometriosis	Infertility	Pleurisy	Skin disease	Vertigo
Cancer	Fibromyalgia	Ingrown toenails	Pneumonia	Sties	Warts
Canker sores	Flu	Joint pain	Psoriasis	Stroke	Whooping Cough
Chicken pox	Gallstones	Kidney Disease		Sun stroke	Worms
Other?					

Have you had any infectious disease from which you have never fully recovered?

____

What operations have you had?

Operation	When	Complications

What major injuries have you had?

Injury	When	Long term effects
______________________________	___________________	_______________________
______________________________	___________________	_______________________
______________________________	___________________	_______________________

Age of first menses? _______ Number of pregnancies:_________ Miscarriage/abortion:___________

Any adverse effects from vaccinations?____

Have you ever taken antibiotics for a prolonged period of time?______________

For what condition?____

When was your last physical exam?_______________

Have you lost any weight lately?____________ How many pounds?____________ What exercise do you do?_________________________________

How frequently do you exercise?____

How much of the following are you using: Tobacco__________________

Coffee_______________Tea__________________ Alcohol__________________

Recreational drugs_____________________

Which of the following have affected your relatives?

(Please circle all that apply)

Alcoholism	Depression	Heart disease	Pneumonia
Allergies	Diabetes	High blood pressure	Skin disease
Arthritis	Epilepsy	Mental illness	Syphilis
Asthma	Gonorrhea	Paralysis	Tuberculosis
Cancer	Gout		

Relative	Age if alive	Age at death	Ailments
Mother			
Father			
Brother(s)			
Sister(s)			
Children			

Are you currently under the care of another health professional?

Specialty	For what condition(s)	Treatment