

Jacksons Wellness and Nutrition

CLIENT INFORMATION FORM

Please Print Clearly

Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: Cell _____ Home _____

Referred By: _____

Thank you for taking the time to complete this form. Please use reverse side (if necessary) when completing requested information.

What prompted you to request a Body Scan?

Do you have experience with the following?

Homeopathy _____ Electro Acupuncture _____ Biofeedback _____ Herbal Remedies _____

Other (please explain):

Do you regularly use or eat the following: If so, how many times per week?

White Sugar _____ White Flour _____ Alcohol _____ Aspartame _____ Regular Coffee _____ Decaf Coffee _____

Tobacco _____ Carbonated Drinks _____

Briefly describe your diet: Regular _____ Junk Food _____ Vegetarian _____

List all dental surgeries and procedures: root canals and crowns; materials used; and year.

1. _____ Year: _____

2. _____ Year: _____

3. _____ Year: _____

4. _____ Year: _____

Last dental visit: _____ Result: _____

List all medications currently being taken and what they treat (Example: Metformin for diabetes)

List all supplements currently being taken and what they are for. (Example: Melatonin for sleep)

List surgeries, injuries and accidents:

1. _____ Year _____

2. _____ Year _____

3. _____ Year _____

Please indicate if you have had any organs removed or transplanted

1. _____ Year _____

2. _____ Year _____

Do you have any of the following:

Pacemaker/Defibrillator _____ Stents _____ Shunts _____ Electric Muscle Tense unit _____

Signature: _____ Date: _____