WELLNESS CARE TODAY

CLIENT HEALTH FORM

Please Print

Turn page over if more space is needed

Name	Home Phone
Address	Cell Phone
City	Birthdate
State	Age
Zip	M/F
Email	Marital Status
Employer	Occupation

In case of emergency, please notify:

Name	Phone
Relationship	
Doctor's Name	Phone
Are you currently under a doctor's care? For what condition?	

Please list all accidents and operations:

Date	Description
Date	Description
Date	Description

Please list any medications you are taking:

Please circle any of the following items you take regularly:

Aspirin/Motrin/Other	Vitamins/Minerals	Herbs	Anti-Depressants
Insulin	Sleeping Pills	Alcohol	Other Drugs

Please circle any symptoms/problems you are currently experiencing:

Allergies	Arthritis	Fatigue	Numbness/Tingling
Headaches	Back Problems	Edema	Blood Pressure – hi/low
Diabetes	Ulcers	Heart Problems	AIDS
Cancer	Insomnia	Sciatica	Pregnancy

Family history of diseases and which side of the family:

	Mother	Father
	Mother	Father
	Mother	Father

How did you hear of Wellness Care Today?

This request for information does not imply, in any way, the practice of medicine or diagnosis of a client's condition. Wellness Care Today reserves the right to restrict service to, or decline acceptance of, the client.

This is to certify that I am requesting services on my own behalf, or on behalf of my child. I realize that Wellness Care Today does not diagnose ailments or prescribe treatment. I release Wellness Care Today from any liability for claims resulting from the use of its services.

SIGNATURE_____ DATE_____