Love, Light and Healing
Natural Health Clinic

Client Information Form

The object of our clinic is to assist you in resolving your health concerns using natural methods. Although fully trained, we are not permitted to give a diagnosis regarding your condition nor can we prescribe, only recommend. All recommendations are based on the medical history and symptoms which you provide to us. Inaccurate or incomplete information will hinder our ability to provide you with the best recommendations possible.

Whenever possible we endeavor to work with your doctor to provide you with the optimum in health care. If your doctor requires information on the treatment you are pursuing, please let us know, we would be happy to provide you with a written report. Should a diagnosis be required to provide the best recommendations possible, we will refer you to your medical doctor for further assessment. If you are currently under a doctor's supervision please do not discontinue this treatment without first discussing it with your doctor and our staff.

I have read and acknowledge the two paragraphs above and I recognize that an herbal treatment program must be followed as it has been recommended to be safe and truly effective.

Signed _____ Date _____

Name _____ Email _____

Address _____

City _____ Postal Code _____

Phone _____

Doctor's name: _____ Phone Number _____

Note: Your doctor will not be contacted without your permission.

Date of Birth: (M)_____(D)_____(Y)_____

Profession: _____ Relationship Status: _____

Do you have any allergies or sensitivities to any medications, foods or plants? Yes____ No____

If yes, what are you allergic to?

_____

_____

_____

_____

_____

_____

Have you had surgery in the past? Yes ___ No ___

If yes, when (M) _____(D)_____

What type of surgery was it and why did you have the surgery?

_____

_____

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_____

How do you prefer to take your remedies? Please indicate your order of preference by using numbers 1 to 3

Liquid tinctures____ Capsules___ Teas___

Have you had alternative health treatments in the past? Yes___ No___

If so, what type?

_____

Have you ever experienced any of these symptoms or medical conditions on an ongoing basis? Please check all that apply.

( ) Headaches
( ) Constipation
( ) High blood pressure
( ) Ringing in ears
( ) Loss of smell
( ) Menstrual irregularity
( ) Rheumatic fever
( ) Muscle spasms
( ) Sleeping problems
( ) Painful joints
( ) Face flushed
( ) Twitching of face
( ) Chest pains
( ) Shortness of breath
( ) T.B.
( ) Indigestion
( ) Intestinal gas
( ) Diarrhea
( ) Hernia

( ) Fainting
( ) Shooting head pains
( ) Kidney trouble
( ) Low blood pressure
( ) Wear glasses
( ) Hay fever
( ) Diabetes
( ) Menstrual cramps & pain
( ) Tightness of throat
( ) Inflammation of throat
( ) Pins and needles
( ) Cold hands or feet
( ) Cold sweats
( ) Liver trouble
( ) Gall bladder trouble
( ) Dizziness
( ) Nerves or nervousness
( ) Prostate problems
( ) Edema

( ) Heart attacks
( ) Loss of balance
( ) Sinus trouble
( ) Cancer
( ) Anemia
( ) Lights bother eyes
( ) Asthma
( ) Loss of taste
( ) Ulcers
( ) Neck pain
( ) Arthritis
( ) Loss of memory
( ) Fatigue
( ) Depression
( ) Swollen ankles
( ) Heart palpitation
( ) Back pain
( ) Muscle pain
( ) Mood swings

Have you ever had any serious falls, accidents or injuries? Yes ___ No ___

If yes, when (M) _____(D)_____

If yes, what type?

_____

_____

_____

_____

_____

Does you have a family history of medical conditions?

If so what type?

_____

_____

_____

_____

_____

_____

Do you wish to receive newsletters and notifications of offers? You are free to unsubscribe at any time. Yes ___ No ___