HEALTH AND BODY RESTORATION CENTER INTAKE FORM

Your Name_____Today's date_____
Mailing address_____

Age_____Birthday (day and month only)_____
Email Address_____
Best Phone # to contact you_____

Please provide health history with current/past diagnosis STARTING WITH MOST RECIENT COMPLAINT. (all information in protected by privacy laws and kept confidential)

_____
_____
_____
_____

Please list all your vitamins and medications (Please use separate sheet of paper if needed)

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____

# of Bowel movements/day_____# Caffeine drinks/week_____# Alcohol/week_____
Ave hours sleep/night____How often do you exercise/week?_____Are you in pain?____
Where?_____Is it getting worse?_____How long have you had this?____

WHAT ARE YOUR HEALTH GOALS? (Give details)_____
_____
_____

What are you willing to do to become and stay healthy? (please check)
Exercise____ Take supplements as recommended_____ Change your eating habits_____ and life style habits_____Come in for regular check ups____
Do simple test at home to monitor your progress_____
* Do You believe your body can heal? yes____ no____
How long do you think it will take you to accomplish your goals?
Days_____ Weeks_____ Months_____ Years_____

What do you expect me to do to help you accomplish your goals?
Figure out what changes are needed and make recommendations_____
Monitor you health and make sure you're progressing_____
Show you what you can do to help yourself_____Do it all for you_____