

BALANCE4LIFE

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43303 Schoenherr Rd., Sterling Heights, MI 48313

CLIENT INFORMATION SHEET

ABOUT YOU:

Name:	Date:
Address:	Phone:
City/State:	Zip:
Email:	Cell:

BACKGROUND/HISTORY:

Sex: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	D.O.B.:
Nationality:	Religion:
Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single	Spouse Name:
Occupation:	Spouse Occupation:
Who referred you to our office:	
Family History:	

MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

Any physical Conditions:	Physician:
<input type="checkbox"/> Heart Condition <input type="checkbox"/> Emphysema	Phone:
<input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Hypoglycemia	Any Operations under anesthesia:
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Epilepsy	When:
<input type="checkbox"/> Diabetes <input type="checkbox"/> M. S.	For what Condition:
<input type="checkbox"/> Asthma <input type="checkbox"/> Sleep Disorder	
<input type="checkbox"/> Arthritis <input type="checkbox"/> Loss of Vision or Contact Lenses	
<input type="checkbox"/> Allergies <input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Drug Abuse	
<input type="checkbox"/> Speech Disorder <input type="checkbox"/> Emotional Trauma	
<input type="checkbox"/> Types of Allergies, if any:	

MEDICATIONS: (PLEASE LIST ANY CURRENT PRESCRIPTIONS OR NON-PRESCRIPTIONS DRUGS/MEDICATIONS YOU ARE TAKING)

_____	_____	_____
_____	_____	_____

PSYCHOLOGICAL HISTORY:

Do you have intense fears? If so, what are they? _____

Have you ever been in psychotherapy? _____ When? _____

Have you ever felt that you have had emotional problems? _____

Please give a brief descriptions: _____