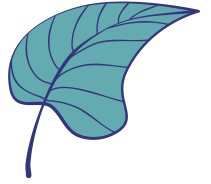




# Client Health Record

## Personal Information

Date: \_\_\_\_\_



Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone# \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Referred By: \_\_\_\_\_ Internet  Flyer  Other

Present Major Concern/Complaint:

\_\_\_\_\_

Current Symptoms: \_\_\_\_\_

Has there been a medical diagnosis:  Yes  No

If so, by whom? \_\_\_\_\_ Rx(s) Prescribed: \_\_\_\_\_

Please explain: \_\_\_\_\_

When did you first notice symptoms/complaints: \_\_\_\_\_

What brought it on: \_\_\_\_\_

Is the condition getting worse:  Yes  No

List other therapies you receive: \_\_\_\_\_

Does this condition interfere with: Work  Sleep  Daily Routine  Sex Life

Please explain: \_\_\_\_\_

What have you tried using to get relief? \_\_\_\_\_

What activities aggravate the condition? \_\_\_\_\_

What activities or products improve the condition? \_\_\_\_\_

Describe the exercise activities you do and how often? \_\_\_\_\_

\_\_\_\_\_

Any allergies (food, drugs, airborne)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Client Health Record

Holistic Health of Long Island  
holistichealthofli@gmail.com  
631-260-6332  
www.holistichealthofli.com



What are your long-term health care goals? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current medications, including vitamins/supplements you are taking:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any additional comments or concerns regarding your health and well-being:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please make sure you fill out the Informed Consent Form and  
email both to: [holistichealthofli@gmail.com](mailto:holistichealthofli@gmail.com)  
Thank you!