

Client Information Sheet

This consultation is intended to improve the use of bio-identical hormones, prescription, non-prescription medicine and products, non-drug approaches to self-care and/or referral to other health care providers.

Name _____ Date _____

Address _____ Age _____ Gender Male Female

City _____ State _____ Zip _____ Birth Date ____/____/____

Day Phone (____) ____-____ Mobile Phone (____) ____-____ Night Phone (____) ____-____

Fax Number (____) ____-____ **Best time to call _____**

E-mail Address _____

Would your prefer test results be mailed, faxed or emailed to you? _____

Height _____ Weight _____ Race _____ Marital Status Married Single

Occupation _____

Whom may we thank for your referral? _____

Blood Type _____

Do you use tobacco? Smoke Chew Other None

Do you use alcohol? None Occasionally How much? _____

Which do you consume most often? Home Cooking Low fat Fast food

How many servings of fruits and vegetables do you consume each day? None 1-3 4-6 7 Plus

How often do you exercise? None Occasional 2-3 Times a week 4-5 Times a week

Pregnant? Yes No Breast Feeding? Yes No

Do you drink filtered or bottled water? Yes No

Food Allergies _____

Supplement Allergies (Vitamins, minerals, herbs, etc.) _____

Medication Allergies _____

Medication Reactions _____

Medical History

- Arthritis
- Bronchitis
- Asthma
- Allergies / Hay Fever
- Emphysema
- Cancer _____
- Chronic Tiredness / Fatigue
- Thyroid dysfunction
- Digestion problems
- Glaucoma
- Angina / Heart Attack
- Heart Disease _____
- Do you have a pacemaker?**
- Do you have a defibrillator?**
- High Cholesterol
- High Homocysteine
- High Blood Pressure
- Diabetes
- Hypoglycemia
- Osteoporosis
- Hormone Imbalances
- Prostate
- Depression
- Headaches / Migraine
- Kidney Disease
- Kidney / Bladder disorders
- Liver Disease
- Chronic Infections

Keith D. Bishop, Clinical Nutritionist

HEALTH NUT RX™ NATURAL CARE SOLUTION

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Please turn this sheet over and complete the next page

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Other health concerns _____

Health Care Providers

Primary Care Physician _____	Phone (____) ____ - _____
Dentist _____	Phone (____) ____ - _____
Chiropractor _____	Phone (____) ____ - _____
Pharmacy _____	Phone (____) ____ - _____

May I contact your health care provider(s) for additional information or to inform them of health concerns that I may have? Yes No

Today's Health Concern(s)

Current Prescription Medications

Current Non-Prescription Medications, Vitamins, Minerals, Herbal Supplements, and Self-Care

Certification Statement of Client: To the best of my knowledge, the information I have entered on this form is correct.

Client Signature _____ Date: ____/____/____

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