FREEDOM WHOLE HEALTH

CONFIDENTIAL CONTACT FORM

Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Sex:_____ Age:_____ Height:_____

Telephone:_____ Email:_____

Occupation:_____

Emergency Contact:_____

Emergency Contact Number:_____

What is your primary reason for your initial visit?_____

_____

Are You currently experiencing an extraordinary amount of stress in your life?

_____

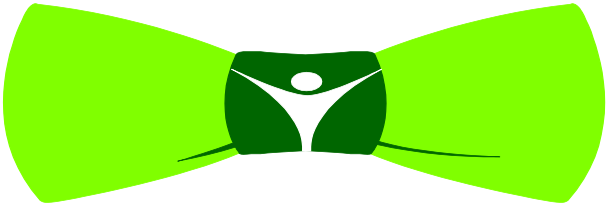
_____

List any medical conditions not listed below.

_____

_____

_____



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HEALTH HISTORY

Musculoskeletal

	Bone or Joint Disease
	Tendonitis/Bursitis
	Arthritis/Gout
	Jaw Pain/TMJ
	Lupus
	Spinal Problems
	Migraines/Headaches
	Osteoporosis

Circulatory

	Heart Condition
	Phlebitis/varicose veins
	Blood Clots
	High/Low Blood Pressure
	Lymphedema
	Thrombosis/Embolism

Nervous System

	Shingles
	Numbness/Tingling
	Pinched Nerve
	Chronic Pain
	Paralysis
	Multiple Sclerosis
	Parkinson's Disease

Respiratory

	Breathing Difficulty/Asthma
	Emphysema
	Allergies, specify:

Skin

	Rashes
	Herpes
	Allergies, specify:

Digestive

	Irritable Bowel Syndrome
	Bladder/kidney ailment
	Colitis
	Crohn's Disease
	Ulcers

Reproductive

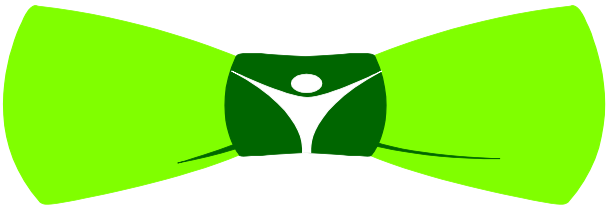
	Pregnant
	Ovarian/Menstrual Problems
	Prostate

Psychological

	Anxiety/Stress Syndrome
	Depression

Other

	Cancer/Tumors
	Diabetes
	Drug/Alcohol/Tobacco use



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Supplements or over the counter medicines taken:_____
_____

_____

Prescription medicatons presently being taken:_____

_____

Responsible Party Signature:_____

Date:_____