

Client Consultation Form

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home: ( ) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Cell: ( ) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OR
Who can we thank for referring you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information is required to ensure your overall care and well-being while receiving services from Abundant Health Float and Day Spa. All information provided will remain completely confidential and will be used to evaluate your personal needs, ensure that those needs are being met, and for home maintenance purposes. Please identify any conditions listed below that are currently applicable (within 6 months) and provide any additional information if necessary below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Allergies |  | Hepatitis |  | Thrombosis |
|  | Asthma |  | Heart Condition |  | Thyroid Conditions |
|  | Arthritis  |  | High Blood Pressure |  | Varicose Veins |
|  | Back Condition |  | Hormone Imbalance  | Recent Surgery |
|  | Cancer |  | Kidney Condition  |
|  | Circulatory Condition |  | Liver Condition | Topical Prescriptions |
|  | Claustrophobia |  | Low Blood Pressure |
|  | Diabetes  |  | Open Wounds |
|  | Epilepsy |  | Osteoporosis |
|  | Fracture |  | Scar Tissue |

Expand/Additional Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Client Signature Date