ALIGN WITH LIFE – ALPHABIOTICS SEDONA
CLIENT INFORMATION FORM

Name: ____ **Date:** ________________

Address: ____

Street **City** **State** **Zip**

Date of Birth: ___________ **Phone:** ________________ **Email:** ___________________________

Emergency Contact: ____

Name **Relationship** **Phone Number**

Have you experienced any major surgical procedures or injuries? ____ **Yes** ____ **No**

If Yes, Please Explain: ____

____

____

Are you currently seeing a Physical Therapist, Chiropractor or Medical Physician for ongoing issues?

____ **Yes** ____**No**

If Yes, Please Explain: ____

____

Please circle your current stress level: Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Please circle your average energy level: Lowest 1 2 3 4 5 6 7 8 9 10 Highest

Please list your persistent stressors:

____

____

What are you interested to accomplish by participating in Alphabiotics?

____

____

Check the following conditions that apply to you, past and present. Please add your comments to clarify the condition. You may use the back of this page if you need more room for writing.

MUSCULO-SKELETAL

___ Headaches
___ Joint stiffness/swelling
___ Spasms/cramps
___ Broken/Fractured bones
___ Strains/Sprains
___ Back, hip pain
___ Shoulder, neck, arm, hand pain
___ Leg, foot pain
___ Chest, abdominal pain
___ Problems walking
___ Jaw pain/TMJ
___ Tendonitis
___ Arthritis
___ Osteoporosis
___ Scoliosis
___ Other: ______________
____

CIRCULATORY/ RESPIRATORY

___ Dizziness
___ Shortness of breath/Asthma
___ Cold feet or hands
___ Cold sweats
___ Stroke
___ Heart condition
___ High blood pressure
___ Low blood pressure
___ Other: ______________
____

DIGESTIVE SYSTEM

___ Indigestion
___ Constipation
___ Intestinal gas/bloating
___ Diarrhea
___ Other: _____________
____

NERVOUS SYSTEM

___ Numbness/tingling
___ Fatigue
___ Ulcers
___ Paralysis
___ Epilepsy
___ Chronic Fatigue
___ Multiple Sclerosis
___ Muscular Dystrophy
___ Parkinson's Disease
___ Other: ___________
____

SKIN

___ Rashes
___ Allergies
___ Acne
___ Other: ___________
____

OTHER

___ Depression
___ Difficulty concentrating
___ Hearing Impaired
___ Visually Impaired
___ Diabetes
___ Fibromyalgia
___ Cancer
___ Vertigo
___ Pregnancy
___ Other: ____________
____

EATING HABITS

___ # of meals/day
___ Consistent schedule
___ Sporadic schedule
___ Skips meals
___ Loss of Appetite

NUTRITION

___ Lactose intolerant
___ Gluten intolerant
___ Egg/Albumen allergy
___ Corn/Soy intolerant
___ Special diet

EXERCISE

Regular exercise: Yes No
# of sessions per week:
____

Type of exercise:
____
____
____

LIFESTYLE

Alcohol: Yes No
Amount: _______________
Frequency: _____________

Smoking: Yes No
Are you interested in stopping? Yes No

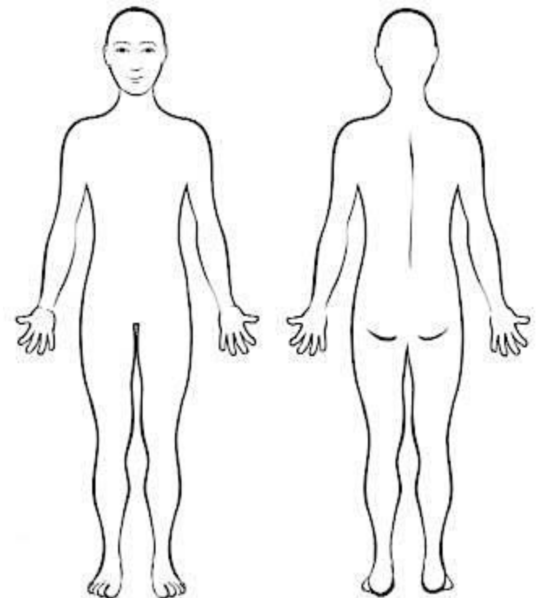
Caffeine: Yes No
Servings daily: _________

Water Glasses daily: ____

SLEEP

___ Difficulty falling asleep
___ Awakens frequently
___ Early morning awakenings
___ Daytime drowsiness

Please mark on the drawing where you feel tension from stress



I acknowledge and fully understand that a Developmental Alphabioticist (DA) is not a medical doctor, chiropractor, or therapist. I understand that the information provided by me on this form is for the strict purpose of providing my DA with information about my wellness history so that he/she might have a clearer understanding of how and where chronic stress is affecting my person. I promise that I have stated all of the conditions that I am aware of, and this information is true and accurate. I will promptly inform the Alphabioticist of any changes in my wellness status.

Client's signature___________________________________ Date______________________