

CLIENT INFORMATION FORM

Kindly ***PRINT CLEARLY*** and complete ***ALL*** three pages.
It's very important that we can read what you put down!

NAME _____ DATE _____

STREET ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (home) _____ (work) _____

DATE OF BIRTH _____ OCCUPATION _____

E-MAIL ADDRESS _____ SPOUSES'S NAME _____

PHYSICIAN _____ ADDRESS _____

REFERRED BY _____ PRIMARY REASON FOR VISIT _____

cell phone: _____

PLEASE CIRCLE THE APPROPRIATE ANSWER:

Have you ever had surgery? YES / NO Describe _____

Do you have skin problems? YES / NO Describe _____

Are you on medication? YES / NO Describe _____

Do you have spinal problems? YES / NO Describe _____

Are you pregnant? YES / NO If yes, what trimester are you in? _____

Do you experience strong emotions YES / NO Describe _____

Do you presently have any blood clots? YES / NO Describe _____

Do you suffer from allergies? YES / NO Describe _____

Do you have areas needing special attention? YES / NO Describe _____

PLEASE CIRCLE ONLY THE PROBLEMS EXPERIENCED DURING THE LAST 12 MONTHS.

- | | | |
|-------------------|---------------------|------------------|
| Abscess | Hayfever | Phlebitis |
| Acne | Headaches | Prostate |
| Alcoholic | Hearing | Pyorrhea |
| Allergy _____ | Heart | Rash |
| Anemia | Hemorrhoids | Rheumatism |
| Appetite low/high | Hepatitis | Schizophrenia |
| Arthritis | Type _____ | Sciatica |
| Asthma | Hives | Sciatica |
| Backache | High Blood Pressure | Sclerosis |
| Bad Breath | Hypoglycemia | Sex Drive-low |
| Bed Wetting | Brain Damage | Sex Drive-high |
| Bladder | Bronchitis | Sinus |
| Boils | Bruises | Speech |
| Bones | Bursitis | Sterility |
| Bowels | Jaundice | Teeth |
| Candida | Joints | Impotence |
| Carpal Tunnel | Kidneys | Infections |
| Cholesterol | Kidney Stones | Insomnia |
| Chronic Fatigue | Lethargy | Itch |
| Colds | Memory | Tremors |
| Colitis | Menopause | Twitch |
| Constipation | Menstruation | Ulcers |
| Convulsions | Mental Disorders | Underweight |
| Cramps | Migraine | Varicose Veins |
| Diabetes | Miscarriage | Vaginitis |
| Diarrhea | Mononucleosis | Yeast Infections |
| Digestion | Muscles | LIST OTHER |
| Depression | Muscle Spasms | CONDITIONS |
| Dizziness | Nausea | BELOW: |
| Ears Ringing | Nerves | _____ |
| Eczema | Emphysema | _____ |
| Fatigue | Endometrioses | _____ |
| Fever | Epilepsy | _____ |
| Fibromyalgia | Eyes | _____ |
| Fingernails | Neck Problems | _____ |
| Fungus | Numbness | _____ |
| Gums | Obesity | _____ |
| Hair | Parkinson's | _____ |

ARE YOU CONNECTED TO ANY GOVERNMENT AGENCY? YES / NO

If yes, list agency _____ Reason for visit _____

ARE YOU CONNECTED TO ANY MEDICAL ASSOCIATION? YES / NO

If yes, list association _____ Reason for visit _____

I, (your name) _____, fully understand that methods used by Randy Sutton or any other therapist at Sutton Alternative Health Services, Inc. is given for the purpose of stress reduction, relief from muscle tension or spasm, or for improving energy flow. Further, I fully understand that Randy Sutton or any other therapist at Sutton Alternative Health Services, Inc. do not diagnose illness, disease or any other physical or mental disorder. As such, Randy Sutton or any other therapist at Sutton Alternative Health Services, Inc. do not prescribe medical treatment, pharmaceuticals, nor does he perform any spinal manipulations or physical therapy. It has been made very clear to me that any of the therapies that are performed at Sutton Alternative Health Services, Inc. are not a substitute for medical examinations and/or diagnosis. *I understand that Electro dermal Screening is not understood to be a diagnostic tool. We at Sutton Alternative Health Services, use this method to track the fluctuations in the core energy of the body. With each session we record the energy, helping us see if what we are doing is improving your internal energy.*

IT HAS BEEN MADE VERY CLEAR TO ME THAT RANDY SUTTON IS NOT A MEDICAL DOCTOR.

IMPORTANT! Because Massage Therapists and Reflexologists must be aware of existing conditions, I have stated all my known medical conditions and I take it upon myself to make Randy Sutton aware of any and all changes to my physical health. Signing below indicates that you read and agree to the above statement.

SIGNATURE _____ **DATE** _____

WITNESS _____ **DATE** _____

To enable me to make your session as effective as possible, it is important that you answer every question as accurately and completely as possible. Be assured that your information will be held in the strictest confidence.

My sincere desire is to provide the most effective care to each person as the unique individual that they are. To that end, please list any additional information that you feel may help me to help you more fully.

We will work together as partners to reach the ultimate goal of your optimal health.