



@theimagecenter

C L I E N T R E G I S T R A T I O N

CONTACT INFORMATION			
TITLE <input type="checkbox"/> MR. <input type="checkbox"/> MISS <input type="checkbox"/> MRS. <input type="checkbox"/> DR.		NAME (LAST NAME FIRST)	
ADDRESS		CITY	DATE OF FIRST VISIT
		STATE	ZIP CODE
DATE OF BIRTH	E-MAIL	HOME PHONE	CELL/PAGER
HOW DID YOU HEAR ABOUT US?			

MEDICAL HISTORY (CHECK ALL THAT APPLY)			
GENERAL:			
<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> AREA OF INFLAMMATION : _____	
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SEIZURES/CONVULSIONS	<input type="checkbox"/> INFECTIOUS CONDITION: _____	
<input type="checkbox"/> CHEST PAINS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> ALLERGIES: _____	
<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> HORMONAL PROBLEMS	<input type="checkbox"/> SKIN CONDITON/RASH: _____	
<input type="checkbox"/> BRUISE EASILY	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> THYROID (OVER OR UNDER)	<input type="checkbox"/> OSTEOPOROSIS
<input type="checkbox"/> VARICOSE VEINS/PHLEBITIS	<input type="checkbox"/> ASTHMA OR BEATHING PROBLEMS	<input type="checkbox"/> JOINT DISORDER	<input type="checkbox"/> NUMBNESS/PARALYSIS
ARMS:			
<input type="checkbox"/> SHOOTING PAINS	<input type="checkbox"/> LOSS OF STRENGTH	<input type="checkbox"/> COLD HANDS	
ABDOMEN:			
<input type="checkbox"/> NAUSEA	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> GAS	<input type="checkbox"/> DIARRHEA
<input type="checkbox"/> APPENDICITIS	<input type="checkbox"/> LIVER PROBLEM	<input type="checkbox"/> KIDNEY PROBLEM	<input type="checkbox"/> STOMACH ACIDITY
<input type="checkbox"/> DIGESTIVE PROBLEMS	<input type="checkbox"/> ULCERS		
PELVIS:			
<input type="checkbox"/> OVARY PROBLEMS	<input type="checkbox"/> PROSTATE PROBLEMS	<input type="checkbox"/> PAINFUL CRAMPS: _____	
HEAD:			
<input type="checkbox"/> HEADACHES	<input type="checkbox"/> MIGRAINES	<input type="checkbox"/> LIGHTHEADEDNESS	<input type="checkbox"/> RINGING IN EARS
<input type="checkbox"/> LOSS OF MEMORY	<input type="checkbox"/> ACCIDENT/STITCHES: _____		
PLEASE LIST ANY OTHER MEDICAL CONDITIONS OR SYMPTOMS: _____			
DO YOU HAVE ANY IMPLANTS (PACEMAKERS, PINS IN BONES, ETC.)? _____			
PLEASE LIST ANY ORAL MEDICATIONS YOU CURRENTLY TAKE (INCLUDE HORMONES ,BIRTH CONTROL PILLS, ANTIBIOTICS, TRANQUILIZERS, ANTI-DEPRESSANTS, DIURETICS, ETC.): _____			
ARE YOU CURRENTLY OR HAVE EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEMS? (IF YES, EXPLAIN) _____			
_____ NAME OF PHYSICIAN: _____			
LIST ANY HISTORY OF SURGERY PROCEDURE INCLUDING COSMETIC SURGERY & DATE: _____			
_____ NAME OF PHYSICIAN: _____			
CLIENT SIGNATURE: _____		DATE: _____	