Back2Balance **NEW CLIENT INFORMATION FORM**

Name	Date
Address	City/State/Zip
Phone	Email
Date of Birth | Age	Referred By

Which screenings you interested in today?

☐ Food Sensitivities ☐ Nutritional Deficiencies ☐ Custom/comprehensive

☐ Environmental Sensitivities ☐ Vertebral & Soft Tissue ☐ Dental Disturbance

☐ Hormone Imbalance ☐ Emotional Disturbances ☐ Supplement Check

List in order of importance your current primary health concerns

1)	4)
2)	5)
3)	6)

Current or previous treatments for above concerns (if any) ___________________________________

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Have you ever been tested for food sensitivities? _________ How long ago? ________

If so, what foods are/were you sensitive to?

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