Confidential Patient Information

Name: ____

Address: ____

Email: ____

Home Phone: ____________________ Business/ Mobile Phone: ____________________

Date of Birth: ____________________ Occupation: ____________________

Recommended by: (I'd like to say "thank you") ____________________

Main Health Problems: ____

____

Previus Health Care: (eg. chiropractic, naturopathy, etc.) ____________________

Current Therapy: ____

Medication: ____________________ Supplements: ____________________

Surgery: ____________________ Broken Bones: ____________________

Family History: ____

Accidents/Trauma: (including emotional) ____________________

____

Dietary Comments: ____________________ Cravings: ____________________

Allergies: ____________________ Dislikes: ____________________

Exercise: ____________________ Frequency: ____________________

Desired Outcome Today: ____

Patient's Signature: ____________________ Date: ______/______/______

Parent/Guardian: (If under 18 years of age) ____________________

Pam Sussman KINESIOLOGIST

THE simple PATH®