Mind Body WORKS
Village Commons • 620 Village Drive • Virginia Beach, VA. 23454
757.351.3332 • fax: 757.351.2544

Nutritional Consulting

Registration Information
(Please Print)

Date: _____ **Home Phone:** _____
Cell Phone: _____
Email:_____

Client: _____
(Last Name) (First Name) (Initial)
Responsible Party (if a minor): _____
Street Address: _____
City _____ State: _____ Zip Code: _____
Sex: Male__ Female__ Age: ___ **Birthdate:** _____ Marital Status: _____

Employed: __ Unemployed: __ Student: __ School Attending: _____
Patient Employed By: _____
Business Address: _____
Occupation: _____ Business Phone: _____
Spouse's Name: _____
Business Name and Address: _____
Occupation: _____ Business Phone: _____
Who is responsible for this account? _____ Relationship: _____
Social Security #: _____ Spouse's Social Security #: _____

___ I have consulted with a physician before starting nutritional consulting
Or
___I have decided to independently not to consult with a physician because I have no reason to suspect any problems.

I understand and agree that I participate at my own risk.

_____ _____
Client/Responsible Party Signature **Date**

Medical History:

- ☐ Allergies_____
- ☐ Arthritis_____
- ☐ Back Problems__U__M__L
- ☐ Brakes/Fractures (where/when)_____
  _____
- ☐ Cancer_____
- ☐ Diabetes
- ☐ Dislocations_____
- ☐ Edema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headaches
- ☐ Heart Problems_____
- ☐ Herpes
- ☐ Hernia_____
- ☐ HIV/AIDS
- ☐ High Blood Pressure
  - ☐ controlled by medication
- ☐ Hypoglycemia
- ☐ Low Blood Pressure
- ☐ Neurological Disease_____
- ☐ Muscle Cramping _____
- ☐ Neck Problems_____
- ☐ Osteoporosis_____

Skin Problems:

- ☐ Eczema_____
- ☐ Psoriasis_____
- ☐ Rashes_____
- ☐ Other_____

- ☐ TMJ
- ☐ Varicose Veins_____

Are you pregnant? ____ How many weeks?_____

Any other health issues?_____

_____

Please list any medications you are currently taking_____

_____

Please list any previous surgeries_____

_____

Signature_____Date _____