Body, Soul & Spirit A Trichology Clinic

A Jarmstead Unlimited Corporation
Est. Lic. #A215165

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CLIENT HISTORY FORM

►Please fill out the **Client History Form** and **ALL OTHER pertinent documents** ACCURATELY & COMPLETELY! These documents are records proving either you are a client and/or have had services rendered or participated in a trichology consultation and open clinic at Body, Soul & Spirit-A Trichology Clinic (A Jarmstead Unlimited Corporation). This is also for our Trichology Division's insurance purposes. We consider Body, Soul & Spirit-A Trichology Clinic a "clinical facility" and take the services rendered, consultations and open clinic very seriously. Therefore, we expect our polices and procedures to be regarded in the same manner. Failure to fill out the Client History Form and all other pertinent documentation **completely**, means you **WILL NOT BE** serviced or consulted at our salon or by The Trichology Division. **ALL INFORMATION IS HELD IN STRICT CONFIDENCE, AND IS ONLY VIEWED BY AUTHORIZED EMPLOYEES OF BODY, SOUL & SPIRIT-A Trichology Clinic (A Jarmstead Unlimited Corporation) and Rodney Barnett, (Certified Trichologist & Natural Health Professional located in Dallas, Texas – www.rodneybarnett.com.) PLEASE PRINT ALL INFORMATION CLEARLY. Thank you for your cooperation.**

Date __________ First Name ______________________________________ Last Name ______________________________________

Street/Mailing Address ____

City ____ State __________ Zip Code _______________

Telephone (home) (__________) - __________ - ____________ Telephone (work) (__________) - __________ - ____________

Telephone (cell) (__________) - __________ - ____________ Telephone (pager) (__________) - __________ - ____________

E-mail Address ___

Birthdate (month/day **ONLY**) ______/______ **(Office Use Only #_______)** Driver's License/Photo ID#____________________ State _______

Sex _______________ Age__________ Height __________ Weight __________ Marital Status ______________________

Occupation ____ at ____

►**IMPORTANT:** For the security of all parties involved, we ask that if the client is age **15 YEARS AND UNDER** or **ELDERLY AND DISABLED (MENTALLY/PHYSICALLY)**, that a parent or legal guardian/custodian signs giving them permission to be serviced in our salon or consulted by Body, Soul & Spirit-The Trichology Division.

I, ____________________ am giving permission for my child/other, ____________________ to be serviced at Body, Soul & Spirit.

Signature by a **PARENT and/or LEGAL GUARDIAN/CUSTODIAN ONLY!** Signature ____ Date __________

►**Please complete the following questions. This will give us a detailed understanding of your present health condition. We will review this form and review it with you. If you have any questions or do not understand any portion of it, we will be happy to assist you.**

CHIEF COMPLAINT

(Primary reason you are seeking treatment) ____

____

Date of last physical examination ____________ Where? ____

Are you presently or recently been under a physician's care? **Yes** **No** If so, date ______________________________

Are you receiving medical treatment? **Yes** **No**

Have you had surgery? **Yes** **No** If so, what was your age at the time of surgery ______________________________

Prescription medications you are presently taking:

1________________________ **2**________________________ **3**________________________ **4**________________________

CLIENT HISTORY FORM (continued)

Client ID# ____________

Supplements or over-the-counter medications you are taking, such as vitamins or ibuprofen:

1________________________ **2**________________________ **3**________________________ **4**________________________

► Please check any known family medical disorder that exists.

	Mother	**Father**	**Sibling**	**Other Disorders**
Allergies	________	________	________	____________________
Asthma	________	________	________	____________________
Heart Disorder	________	________	________	____________________
Cancer	________	________	________	____________________
Arthritis	________	________	________	____________________
Kidney Disorder	________	________	________	____________________
Diabetes	________	________	________	____________________
Stomach Disorder	________	________	________	____________________

Other Complaints ____

____

Have you ever been diagnosed with any of the following conditions?

___ **ulcers**
___ **disease of the colon**
___ **heart disease**
___ **blood pressure**
___ **cholesterol problems**
___ **disease of the kidney/bladder**
___**memory loss**
___ **arthritis**
___ **skin problems**
___ **tobacco user**
___ **lung/sinuses**
___ **diabetes**
___ **fatigue/exhaustion**
___ **hypothyroidism**
___ **menstrual problems**
___ **menopause**
___ **depression**
___ **insomnia**
___ **muscle pain**
___ **osteoporosis**
___ **are you presently pregnant**

List your present health concern: (please describe) ____

____

Habits (circle all that apply): **Alcohol** **Chocolate** **Cigarettes** **Coffee** **Laxatives** **Sugar or Substitutes** **Tea**

Your present weight is _________ lbs. Do you consider yourself to be: **Overweight** **Average** **Underweight**

How many 8 oz glasses of water do you drink each day? _________

List any foods you crave:

1________________________ **2**________________________ **3**________________________ **4**________________________

For Office Use ONLY: FD ID# __________ ☐ SALON CLIENT ☐ ENTER'D ☐ TYPE/TERMS/REP/MAIL PREF ☐ WELCME PC ☐ REFRRL PC ☐ NC PACK