

Customer Profile

KDA _____

Name _____

D.O.B _____ Gender M—F Occupation _____

Address: _____

PH # () _____ E-mail _____

Lifestyle: Please mark and or circle what describes you the best.

Do you work out? Y/N How do you rate your health condition % _____

Smoke? Y/N Drink water? Y/N Coffee? Y/N Sodas? Y/N

Stress Level 1 2 3 4 5 6 7 8 9 Under any medication? Y/N

Pain relievers Y/N Blood thinners? Y/N Vitamins? Y/N Psychotropic Y/N

Please describe _____

What grade would you put to your daily diet: A B C D E F

Do you suffer from any of these conditions and at what level on scale of 1 -9:

Neck Pain or stiffness __ Back __ Lower/Upper Shoulders __ Arms _____

Wrist (Metacarpal syndrome) __ Fingers (numbness) __ Hips __ Legs __ Knees __

Feet __ Headaches __ Slow metabolism __ Bruce easily __

Would you like to know more about the benefits of natural, alternative and preventive medicine? Y/N Can we contact you for that matter? Y/N

I hereby give my consent and authorization voluntarily and release Coty Barnes from any claims, implied or stated that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions given have been explained to me in detail and that I fully understand.

Client signature

Date