Date: ______________ Referred By: ______________________________________

Name: ____ Birth Date: ______________

Address: ____ Weight: ______ Height: ______

____ Marital Status: ______________

Home Tel # __________________ Work Tel. # __________________ Children: ______________

Cell # ____________________ Email: __________________________ Occupation: ______________

Main Complaint:

____

____

Energy: _______ Dizzy: ________ Fever: ________ Chills: ________ Sore throat: ________

Medical History:

Injuries ______________________________ Pacemaker __________________________________

Surgeries _____________________________ Acupuncture/Herbs __________________________

High/Low B.P. _________________________ Chiropractic Care __________________________

Heart disease _________________________ Homeopathic Care ___________________________

Hepatitis _____________________________ Psychological Counseling ___________________

HIV/Aids ______________________________ Nutritional Counseling _____________________

Cancer ________________________________ Diet _______________________________________

Diabetes ______________________________ Colonics ___________________________________

Asthma ________________________________ Pregnancy __________________________________

Allergies _____________________________ Medication _________________________________

Seizures ______________________________ ____

Other _________________________________ ____

Family History:

Mother: ____

Father: ____

Adi Notes:

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I understand that all treatment given to me by Adi Herman is in no way intended to replace proper medical care under the supervision of an M.D. or an otherwise licensed medical or health care practitioner:

Signature: ____