LONGEVITY MOUNTAIN HERBS & HEALTH CLINIC

Mark Hammer, Certified Master Herbalist

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Client Intake Form

Email Address:				Date:	
Name:		Hm Phn:		Wk Phn:	
Address:		City:		State:	Zip:
DOB	Age	Sex: M F	Ht: ft. inch	Wt. lbs.	
Marital Status: (circle) single married divorced other			Profession:		
Blood Pressure:	Pulse:	Temperature:	Cholesterol		
Referral Source:					
Purpose of Consult:					
Medications:					
Past Operations:					

Payment is due at time of service unless special arrangements are made in advance. Signature below authorizes and consents to care by Longevity Mountain, Health Clinic & staff. I will call the staff, if there is any problem and come in for appointment(s) for adjustment in formulation, if needed. I understand that diet, weather, lifestyle, thought, emotions and physicality all have bearing on outcome and may determine the term of correction. With severe chronic conditions, it took time to arrive at imbalance and will need your patience to naturally resolve without causing further adverse effects.

Client signature	Date	Parent signature if minor

DO NOT WRITE BELOW THIS LINE

Constitution:		
Herbal Remedy:		
Regimen:		
Credit Card:	Date:	Code: