L.I.F.E. Adult Consultation Form
Basic Information

PLEASE PRINT

Name: _____ Date: _____

Street / P.O. Box: _____

City: _____ State: _____ / Province: _____ Zip/PC: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

E-mail: _____

Occupation: _____

Birth Date: _____ / _____ / _____ Birth Time – optional: _____
Month Day Year

Birthplace: City: _____ State: _____

Purpose of your visit: _____

_____ I am pregnant or may be pregnant.
_____ I wear a pacemaker.

I understand that a minimum of a 24-hour notice is required for cancellation of appointments. A broken appointment fee is charged to my account and is payable by me if a 24-hour notice is not given.

Client Signature: _____ Date: _____

Please read and sign the attached informed consent form. *Thank you.*

Whom may we thank for your visit with us today? _____

Thank you for taking charge of your health.
Let us know if you have any questions or concerns.