



Frequency-Reconnect Client Questionnaire

Name: _____

Address: _____

Phone: _____

Birthdate: _____

Sex: M or F

Current medications or supplements:

Family History:

Mother: Living or Deceased

If deceased what was the cause:

Grandparents on Mother's side:

Grandmother: Living or Deceased

If deceased what was the cause and the age:

Grandfather: Living or Deceased

If deceased what was the cause and the age:

Father: Living or Deceased

If deceased what was the cause and the age:

Grandparents on Father's side:

Grandmother: Living or Deceased

If deceased what was the cause and the age:

Grandfather: Living or Deceased

If deceased what was the cause and the age:

Siblings:

Brothers: Yes or No

How many? _____

Ages: _____

Living or Deceased

If deceased, why and at what age/s

Sisters: Yes or No

How many? _____

Ages: _____

Living or Deceased

If deceased, why and at what age/s

1. What is your main complaint? Please be as detailed as possible.

2. Can you please explain when this ailment first occurred?

3. What circumstances make this ailment better or worse?

4. Do you currently have any specific food cravings?

5. How is your sleep and what is your current sleeping pattern?

6. Do you have any recurring dreams?

