QRA Client Information Form

Name_____ Age_____ pH_____ Hydration_____

Phone: (C) _____ (H) _____ (W) _____

Address (City, State, Zip) _____

Email (please print) _____

How many bowel movements do you have? Daily_____ Weekly_____

Describe your daily eating habits on a typical day:

Breakfast:_____

Snack:_____

Lunch:_____

Snack:_____

Dinner:_____

Snack:_____

What beverages do you drink daily? _____ How much water do you drink daily? _____

Do you use artificial sweeteners? YES / NO How much alcohol do you consume daily? _____

Do you consume salt? YES / NO If YES, How much per day? _____ What kind? IODIZED / SEA

How many times per week do you eat fast food? _____ How many times per week do you eat out? _____

Do you take any medications? YES / NO If YES please specify: _____

_____

I have completed this information to the best of my knowledge. I understand this QRA test is designed to be a health aid and is in no way to take the place of a doctor's care. Information exchanged during my test is educational in nature and is intended to help me to become more familiar and conscious of my health status.
All information is private and confidential.

Name: _____ Date: _____

For Office Use Only:

Teeth: _____ Infections: _____

Calcium: _____ Diet: _____ Surgery: _____