Center For Life Enhancement

Bryce Britton, MS

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CLIENT INFORMATION

PERSONAL INFORMATION

LAST NAME: FIRST NAME:

STREET ADDRESS:

CITY:

STATE: ZIP CODE:

EMAIL ADDRESS:

PHONE/MOBILE:

DATE OF BIRTH: MALE FEMALE

BEST TIME TO REACH YOU:

HOW DID YOU HEAR OF ME:

REASON FOR SEEKING TREATMENT:

MARITAL STATUS: HOW LONG?:

DO YOU LIVE WITH SOMEONE?:

RELIGIOUS/SPIRITUAL ORIENTATION:

OCCUPATION:

HOBBIES:

PHYSICAL CONDITION: LAST EXAM:

MEDICATION?: IF YES, TYPE:

CARDIOVASCULAR ISSUES? IF YES, DESCRIBE:

DIABETES?: IF YES, DESCRIBE:

PLEASE DESCRIBE SEXUAL PROBLEM :

WHEN DID YOU FIRST NOTICE THE PROBLEM?:

OTHER TYPES OF TREATMENT SOUGHT:

DO YOU EXERCISE?: TYPE:

TYPICAL DIET:

DO YOU SMOKE?: IF YES, PACKS PER DAY?

OTHER DRUGS?: IF YES, TYPE:

WHAT IS YOUR HEART'S DESIRE FOR YOUR SEX LIFE?:

WHAT IS YOUR IDEAL SEXUAL SITUATION?: