Client Health Information

D.O.B. _____,

Name: _____,

Address: _____ **City** _____ **State** __ **Zip**_____

Phone (Home) _____ **(**Cell**)** _____ **Email**_____

Weight _____ **Height** _____ **Resting HT Rate** _____

Describe symptom(s), condition(s), health issue(s) you would like help with, starting with issue that concerns you most:

Chief Complaint:

When did you first notice this? _____
Is it getting better or worse? _____
Have you sought help for this? _____ If so please describe. _____

Additional Issues: _____

Please check off any symptoms that apply

GI

__ frequent indigestion, or slow digestion
__ loose stools after raw or cold foods
__ Binge eating of sweets, craving
__ frequent nausea
__ sluggishness or lethargy after eating
__ frequent scanty urination
__ feelings of being overwhelmed
__ abdominal gas or bloating
__ diagnosed with G.E.R.D.
__ hemorrhoids
__ deficient or excessive appetite
__ frequently constipated
__ dwell on, or worry about details
__ diagnosed with I.B.S. / diverticulosis

Respiratory/EENT

__ frequents colds or URTIs
__ coughing, sneezing with clear phlegm
__ dry skin, mucous membranes
__ hayfever or other allergies
__ longstanding unresolved emotional issues
__ Frequent congestion of sinus, nose, head
__ shortness of breath, wheezing
__ skin rashes, dermatitis
__ asthma, bronchitis, C.O.P.D.
__ hard to express grief, sadness, emotions

__dry eyes, weak or blurred vision
__ hearing problems. Ringing in ears

GUT KI/BL

__ history of urinary tract infections
__ frequent or difficult urination
__ lack of stamina, tire easily
__ pain during sex
__ BPH
__ kidney stones
__ pain in low back, sacrum, hip
__ loss of or thinning hair
__ uterine cysts
__ bone density issues

Reproductive

__irregular menses
__menopausal hot flashes/night sweats
__fertility/conception issues
__decreased libido
__pain/cramping
__wake at night, difficulty getting back to sleep
__erectile dysfunction

HT/CIRC/METABOLISM

__hypo/hyperthyroidism
__elevated cholesterol
__PAD
__diagnosed with hypertension
__arrhythmias
__Diagnosed heart disease

Musculoskeletal

__muscle/joint pain
__bone/joint trauma injuries
__ROM restrictions
__arthritis
__osteoporosis
__muscle spasm/cramping

Nervous System

__frequent anxiety
__insomnia, especially when overtired
__palpitations when nervous or tired
__mood swings, laugh or cry easily
__mental confusion or disorientation
__stress-related work issues
__easily irritated quick to anger
__difficulty falling asleep
__forgetfulness
__dream disturbed sleep
__ticks or twitching muscles
__stressful personal issues

Additionally, have you ever been diagnosed with:

__cancer
__depression
__diabetes
__ADD/ADHD

Please describe pain; where, frequency, when, intensity, and duration. _____

_____

_____

Are you physically active, describe your activities and exercise regimens _____

_____

_____

Please list all prescription, and OTC drug medications, supplements, vitamins and herbal preparations you take on a regular basis _____

_____
_____
_____
_____

Are you currently being treated for an illness or condition? __ Yes __No

If yes, what condition? _____

What is the treatment protocol? _____

Have you had an x-ray or MRI in the last 12 months __ Yes __ No
If so, for what? _____

Please list any accidents, surgeries you have had. _____
_____

Please list any other facts you feel might be helpful in understanding your current state of health. _____
_____
_____
_____

Please include your most recent blood work (blood lipid profiles, liver enzyme tests, PSA etc) if possible.

Also please include a diary of all foods consumed for a consecutive five-day period of time.