# CLIENT HISTORY

**(CONFIDENTIAL-for Practitioner´s use only)**

## Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Children\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_**

**Reason for Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Current Complementary Therapies / Supplements \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eating Habits / Diet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Amount Daily Intake: Water \_\_\_\_\_\_\_\_Caffeine \_\_\_\_\_\_\_ Alcohol \_\_\_\_\_\_\_\_Cigarette / Tobacco \_\_\_\_\_\_\_

**Exercise Routine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mark the following areas of diseases or symptoms as ‘C’ for current, ‘P’ for past, and ‘CH’ for chronic.**

**Explain if necessary.**

### EMOTIONAL / PSYCH Hyperthyroid Heart Attack URINARY

Depression Hypothyroid Heart Failure Bladder Infection

Eating Disorder **NEUROLOGICAL** Hypertension Kidney Stones

Mood Swings Epilepsy Stroke **REPRODUCTIVE**

Substance Abuse (type) Dizziness **RESPIRATORY** Sex. Trans. Dis. (type)

### AUTO-IMMUNE Insomnia Bronchitis Endometriosis

AIDS / HIV Migraines Emphysema Pregnancies (# & ‘C’)

Allergies **MUSCULO-SKELETAL** Pneumonia Miscarriage (#)

Cancer Arthritis Tuberculosis Abortion (#)

Fatigue Back Pain **DIGESTION**

Fever (chronic) Carpal Tunnel Constipation (chronic)

Fibromyalgia Gout Diabetes **OTHER:**

Fungal Infections (type) Skin Disorder (type) Diarrhea (chronic)

Herpes (type) **E N T** Gastritis

Lyme Disease Earaches (chronic) Hepatitis

Mononucleosis Headaches Hypoglycemia

### ENDOCRINE Jaw Pain Jaundice

Adrenal Insuf. **CARDIOVASCULAR** Liver Disorder

Pituitary Dysf. Angina Ulcers

**Please mark the following areas of diseases or symptoms as ‘C’ for current, ‘P’ for past, and ‘CH’ for chronic.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Crying spells | Change in sleep | Family problems | Angry outbursts | Loneliness |
| Relationship  Problems | Increased nervousness | Eating changes | Social problems | Seeing things |
| Headaches | Work problems | Trouble concentrating | Sadness | Hearing things |
| Change in sexual  activity | Suicidal | Feeling out of  control | Homicidal | Unmotivated |
| Loss of trust in  others | Financial problems | Panic attacks | Weight loss/ gain |  |
| Forgetfulness | Violent feelings | Increased alcohol/  Drug use | Confusion |  |

Please list any traumatic or life threatening events that occurred in your life, and when they happened:

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**What do you hope for and what are your expectations from this session and long- term?**

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**Is there anything else you want to share or want me to know?**

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