Client History Form

PLEASE PRINT CLEARLY - THANK YOU

Name _____ Date _____

Address _____ City _____Zip _____

Phone Home (_____)_____ Work (_____)_____Cell _____

Gender _____ Age _____ Date of Birth _____ Height _____ Weight_____

Occupation _____ How did you hear about us/Referred by _____

Email _____ Emergency contact _____ Phone _____

Doctor _____ Chiropractor _____

Please complete the following questiions as well as you can. This information will help us provide you with the most effective and safest treatment session.

Reason you are coming to see us: _____

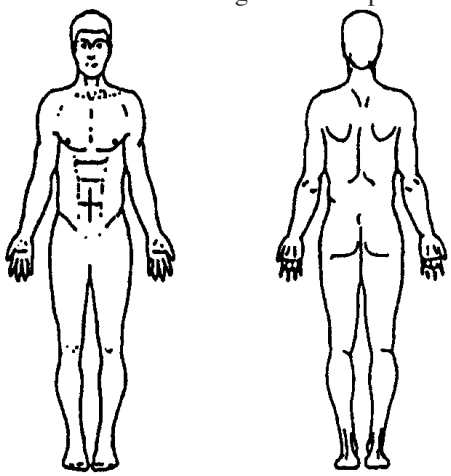
Primary physical complaint: _____

How long have these been occurring? _____

Please indicate on this scale your level of pain: No pain ——— Extreme pain

Please indicate on this scale your ability to function: No limit ——— Extreme difficulty
For example: Range of motion, daily activities, etc.

Please indicate on this diagram where pain or discomfort is occurring.



Any additional comments:

What therapies have you used for this situation?_____

What therapies have been helpful? _____

Are you working with any other health care practitioiner at time time? If yes, what for?

_____

Medications you are presently taking and why: _____

_____

Please list any previous surgeries, injuries, accidents: _____

_____

What type of exercise do you do? _____ How many times per week? _____

Please state what you feel are priorities (ex. health concerns, family, job, activities of interest, etc.)

1. _____ 2. _____ 3. _____

Please state what your goals are for: Week 1: _____

Month 1: _____ Month 3: _____

Do any of the following apply to you?

Y / N Contact lenses Y / N Dentures Y / N Emotional abuse For women only:

Y / N History of psychosis Y / N Suicidal tendencies Y / N Abuse of alcohol/drugs Are you pregnant? Y / N

Y / N Physical/sexual abuse Y / N Working with a mental health care professional Are you trying to get pregnant? Y / N

Please check any of the following conditions that apply to you:

_____ AID/HIV
_____ Anemia/Blood disorders
_____ Asthma/Emphysema
_____ Autoimmune disease
_____ Cancer
_____ Diabetes
_____ Edema/lymphedema
_____ Emotional problems
_____ Epilepsy
_____ Fainting spells
_____ Heart problems
_____ Hepatitis B
_____ High/low blood pressure
_____ Infection Staph or other
_____ Injuries to back, neck or spine
_____ Kidney problems
_____ Liver disease
_____ Recent acute injuries
_____ Rheumatic fever
_____ Osteo-arthritis: location _____
_____ Rheumatoid arthritis
_____ Seizures
_____ Shortness of breath
_____ Skin disorder or infections
_____ Stroke
_____ Sudden weight loss or gain
_____ Tuberculosis
_____ Varicose veins, blood clots or tumors
_____ Veneral disease

_____ Headaches: How often? Location? And when? _____

_____ Chemotherapy, radiation, removal of lymph nodes? Where: _____

I can help provide relief from a variety of conditions including nutritional, emotional and physical stresses. Please check off any of the following items that you would like help with or would like more information about:

_____ Helping my body to relax and release tension and stress
_____ Healing from an injury or surgery
_____ Depression, anxiety or self-esteem issues
_____ Pain of unknown origin or pain that won't seem to get better
_____ Birth via c-section, breech, forceps or other trauma
_____ Emotional stresses or trauma
_____ Feet problems, plantar fascitis & bunions
_____ Dyslexia, time problems, balance
_____ Posture or flexibility
_____ Migraines or headaches

_____ Problems with discs or vertebra of the the spine, bulging discs or scoliosis

_____ Temporal mandibular joint (TMJ) dysfunction, pain, grinding, popping or clenching

_____ Nerve related problems: tinnitus, tingling of nerves, difficulty with senses of hearing, taste, sight

_____ Other, please specifiy: _____

I would like more information about:

❑ Bach Flower Essences ❑ CranioSacral Therapy (CST) ❑ CST for Pediatrics ❑ Enzyme Nutrition
❑ Lymph Drainage ❑ SomaCentric Dialoguing ❑ Visceral Manipulation ❑ Zero Balancing

If there was one thing that we could help you achieve, what would it be? _____

_____

Anything else of importance to you that you would like to share with us? _____

_____

The information that I have provided regarding my health history indicates all conditions including but not limited to medical, physical and mental health conditions known to me at this time. I shall advise Julie Covert, CST-D, NCTMB, BFRP in writing of any and all changes in my health. By signing below I give permission to Julie Covert to contact me from time to time by mail, phone or email. I authorize Julie Covert to contact and share my health information with any health professional that I indicate I am working with.

Cancellation policy: There will be no charge for missed appointments provided that 24 hours notice has been given, otherwise the full cost will be charged to me for all missed appointments.

Signature _____ Date: _____