CLIENT HISTORY

Name:_____Date:_____

D.O.B_____ Age:_____Telephone #:_____

Email:_____Address_____

Primary Physician_____

Emergency contact _____phone number _____

How do you prefer to be contacted? ___text ___email ___phone

Insurance:_____

Occupation:_____ Marital status:_____

Number of children:_____

- **Please describe in your own words your concerns and the reasons you have sought treatment:**

  _____
  _____
  _____
  _____

- **Please describe the effect that you feel these issues have had on you:**

  _____
  _____
  _____
  _____

- **Please describe what your goals for treatment are and the vision you have of where you would like to be:**

_____
_____
_____
_____

- **Please list the areas where you have problems with pain/discomfort and list the number on the pain scale 0-10, where 0 is no pain, 1 is slight discomfort, and 10 is intolerable pain. Also list areas of stiffness and tightness where 0 is relaxed and 10 is like concrete.**

Area: **Pain Score**
Tightness Scale

_____
_____
_____
_____
_____

- **please check the box which best describes the effect the pain/ stiffness has on your ability to perform the following activities:**

-Basic Activities of daily living (e.g. dressing, bathing, grooming,)
___NONE___MILD___MODERATE___SEVERE

-Light housework (e.g. dusting, wiping tables) __NONE ___MILD
___MODERATE
___SEVERE

-Heavy Housework (e.g. cleaning bath, vacuuming) ___NONE ___MILD
___MODERATE ___SEVERE

Light Yard work (e.g. clipping leaves) ___NONE ___MILD ___MODERATE
___SEVERE

-Heavy Yardwork (eg digging, push mower)___NONE ___MILD
___MODERATE ___SEVERE

-Socializing ___NONE ___MILD ___MODERATE ___SEVERE

-Light exercise (e.g. walking, Tai Chi) ___NONE ___MILD ___MODERATE ___SEVERE

-Heavy exercise (e.g. running, aerobics, gym) ___NONE ___MILD ___MODERATE ___SEVERE

-Work: ___NONE ___MILD ___MODERATE ___SEVERE

- **Please check the description that best describes your level of general daily fatigue in the last month:**

  Not out of the ordinary _____

  Only related to outside events e.g. not enough sleep, doing too much___

  None____

  Mild_____

  Moderate___

  Severe____

- **Please check the description that best describes the effect your fatigue has had on your functioning in the following areas:**

  Basic Activities of Daily living: ___NONE ___MILD ___MOD ___SEVERE

  Light Housework: ___NONE ___MILD ___MOD ___SEVERE

  Heavy Housework: ___NONE ___MILD ___MOD ___SEVERE

  Light Yard work: ___NONE ___MILD ___MOD ___SEVERE

Heavy Yard work: ___NONE ___MILD ___MOD ___SEVERE

Socializing: ___NONE ___MILD ___MOD ___SEVERE

Light Exercise: ___NONE ___MILD ___MOD ___SEVERE

Heavy Exercise: ___NONE ___MILD ___MOD ___SEVERE

Work: ___NONE ___MILD ___MOD ___SEVERE

- **Please list any surgeries you have had and approximate date:**

_____
_____
_____

- **Please list any accidents, fractures, car accidents, sports injuries, falls, injuries you have had and approximate age you were:**

_____
_____
_____
_____
_____

- **Please list any traumatic incidents that you feel are not yet resolved, i.e. that still have some effect on you physically or emotionally:**

_____
_____

_____
_____

- **Have you ever suffered any physical, emotional or sexual abuse:**

_____
_____
_____
_____

- **Please list any activities or people/places that give you pleasure and joy and that you love to do/be with:**

_____
_____
_____

- **What do you feel are your strengths and talents:**

_____
_____
_____
_____

- **Do you have or have you ever had any of the following. Please put a check for currently have and a cross for have had in the past:**

__ Diabetes

__Rheumatic fever

__High Blood Pressure

__Cardiac Conditions

__Pacemaker

__Aneurysm

__ Circulatory Problems

__Cellulitis

__Carpal Tunnel

__Plantar Fasciitis

__Strokes

__Blood clots, DVT's

__Scoliosis

__Cellulitis

__ vertigo

__TMJ

5.

__migraines

__Jaw popping

__headaches

__Depression

__Anxiety

__Osteoarthritis

__Rheumatoid arthritis

__General Fatigue

__Epilepsy

__Chronic Fatigue Syndrome

__Malignancy

__Fibromyalgia

__Cancer

__Chronic Lyme's Disease

__Pregnancy

__ Food sensitivities/allergies

__Abortion

__ IBS

__Fractures

__ Insomnia

__Kidney Disease

__Swelling/edema

__Liver Disease

__Brain or head Injury

__Eating Disorder symptoms

__ Gastrointestinal

__Learning Disability disorders

__Neurological

__Drug use

__Alcohol dependency

__Bladder problems

__nausea

- **Are you currently pregnant? ___yes __no**
- **Please list all medications and what you are taking them for:**

  _____
  _____
  _____
  _____

- **Which areas of the body hold stress :**

  _____
  _____

Thank you so much for filling out the client history form! I appreciate your trust. All information is confidential.