

CLIENT HISTORY FORM

Name: _____ Date of Birth: _____
 Phone: (H) _____ (C) _____ Email: _____
 Address: _____
 Occupation: _____
 Primary Care Physician _____
 Telephone # _____
 How did you hear about us? _____
 Did a Health Care Practitioner refer you for your treatment today? Yes No
 If yes, please provide their name, address and telephone number:

MEDICAL HISTORY

Please check all that apply Currently or Previously.

Respiratory

- C P**
- Chronic cough
 - Shortness of breath
 - Smoking
 - Bronchitis
 - Asthma
 - Emphysema
 - Breathing problems
 - Type: _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Poor circulation
- Heart disease
- Phlebitis
- Stroke
- Varicose veins
- Pace Maker
- Other: _____

Infectious Conditions

- C P**
- Herpes
 - Hepatitis
 - Plantar warts
 - TB
 - HIV
 - AIDS

- Skin Conditions
- _____
- Other:
- _____

Women

- Menstrual problems painful?
- Pregnancy
Gestation Age: _____
- Due date: _____

- Menopausal Issues

Head/Neck

- C P**
- Headaches
 - Vision problems
 - Type:
 - Vision
 - Earaches
 - Hearing Loss
 - Sinus

Skin

- Skin conditions
Type: _____
- Bruise easily
- Acne
- Allergies
- Abnormal scarring

Other Conditions

- C P**
- Difficult digestion
 - Constipation
 - Liver
 - Gall bladder
 - Kidney
 - Bladder
 - Dizziness
 - Diabetes
Type: _____
 - Lupus or Autoimmune Deficiency
 - Fibromyalgia
 - Chronic Fatigue
 - Loss of sensation
 - Dizziness
 - Epilepsy

I certify that all of the above information is accurate and correct:

Patient Signature: _____ Date: _____

CLIENT HISTORY FORM

- Insomnia
- Depression
- Anxiety
- Cancer

- Dr. Diagnosed _____
- Arthritis _____
- Affected areas: _____

Current Medications

Name _____
For what condition: _____

Name _____
For what condition: _____

Name _____
For what condition: _____

Surgery

Type _____
Date _____
Current symptoms: _____

Type _____
Date _____
Current symptoms: _____

Type _____
Date _____
Current symptoms: _____

Injury

Type _____
Date _____
Current symptoms: _____

Type _____
Date _____
Current symptoms: _____

Type _____
Date _____
Current symptoms: _____

Other Medical Conditions not listed above:

Additional notes: (pins, wires, artificial joints or limbs, special equipment such as wheelchairs, walker, cane, etc.)

I certify that all of the above information is accurate and correct:

Patient Signature: _____ Date: _____