CLIENT NAME _____ **Date:** _____

MEDICAL HISTORY (Check any of the following that you have experienced in the past or are currently experiencing)

SENSORY
- ❒ Dizziness
- ❒ Ear Infections
- ❒ Failing Vision
- ❒ Hearing Loss
- ❒ Ringing in ears
- ❒ Sinus Trouble
- Other _____

CARDIOVASCULAR
- ❒ Chest Pain
- ❒ Heart Problems
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Pacemaker
- ❒ Phlebitis
- Other _____

RESPIRATORY
- ❒ Asthma
- ❒ Chronic Cough
- ❒ Lung Problems
- ❒ Pneumonia
- Other _____

GASTROINTESTINAL
- ❒ Bloody/Tarry Stools
- ❒ Gall Bladder Problems
- ❒ Irritable Bowel Syndrome
- ❒ Liver Problems
- ❒ Stomach Ulcers
- ❒ Crohn's Disease
- ❒ Ulcerative Colitis
- Other _____
- Other _____

SKIN
- ❒ Rashes/Hives
- Other _____
- Other _____

NEURO/PSYCHOLOGICAL
- ❒ ADD/ADHD
- ❒ Bipolar
- ❒ Depression
- ❒ Memory Loss
- ❒ Mental Illness
- ❒ Multiple Sclerosis
- ❒ Numbness/Tingling
- ❒ Parkinson's
- ❒ Paralysis
- ❒ Peripheral Neuropathy
- ❒ Post Traumatic Stress
- ❒ Seizure Disorder
- ❒ Stroke
- ❒ Tremor/Hands Shaking
- Other _____

MUSCULOSKELETAL
- ❒ Arthritis
- ❒ Bone Injuries
- ❒ Carpal Tunnel
- ❒ Fractures
- ❒ Gout
- ❒ Muscle Weakness
- ❒ Numbness/tingling
- ❒ Osteoporosis
- ❒ TMJ
- Other _____
- Other _____

PAIN
- ❒ Abdominal Pain
- ❒ Back Pain
- ❒ Foot Pain
- ❒ Hip Pain
- ❒ Knee Pain
- ❒ Multiple Joint Pain
- ❒ Neck / Shoulder Pain
- ❒ Fibromyalgia
- ❒ Headaches
- ❒ Migraines
- Other _____

IMMUNE /BLOOD DISORDERS
- ❒ AIDS/HIV
- ❒ Anemia
- ❒ Cancer _____
- ❒ Sickle Cell Anemia
- ❒ Chronic Fatigue
- Other _____

ENDOCRINE
- ❒ Thyroid Disease
- ❒ Diabetes
- Other _____
- Other _____
- Other _____

ALLERGIES
- ❒ Environmental/Chemical
- ❒ Food Allergies
- ❒ Hay fever/Allergies
- Other _____
- Other _____
- Other _____

URINARY/REPRODUCTIVE
- ❒ Prostate Disease
- ❒ Urination Problems
- ❒ Urinary Incontinence
- ❒ Kidney Stones
- ❒ Sexually Transmitted Disease
- Other _____

FEMALES - Please complete
- Pregnant ❒ Yes ❒ No
- Planning Pregnancy ❒ Yes ❒ No
- Fertility Problems ❒ Yes ❒ No
- # of Pregnancies _____
- # of Miscarriages _____
- # of Abortions _____
- Periods ❒ Regular ❒ Irregular
- Birth Control ❒ Yes ❒ No
- Menopausal ❒ Yes ❒ No

ABUSE
- ❒ Emotional
- ❒ Physical
- ❒ Sexual
- ❒ Substance _____

FAMILY HISTORY (check if appropriate)
- ❒ Alcoholism
- ❒ Asthma
- ❒ Bleeding Disorder
- ❒ Cancer
- ❒ Diabetes
- ❒ Hypertension
- ❒ Heart Disease
- ❒ Kidney Disease
- ❒ Mental Illness
- ❒ Migraines
- ❒ Osteoporosis
- ❒ Thyroid Disease
- ❒ Stroke
- ❒ Other _____

ADDICTIVE BEHAVIOR(s) (Type, how long)
_____
_____
_____
_____

Medications/Supplements
List all prescription and non-prescription medications (Please attach separate page if list is too extensive for space allowed)

_____ ____ _____
_____ ____ _____
_____ ____ _____
_____ ____ _____
_____ ____ _____
_____ ____ _____

Hospitalizations & Surgeries
Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____
Date _____ Reason _____

Relationship Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Significant Relationship
- ☐ Widowed
- ☐ Children _____

Occupation
- ☐ Hours worked/week _____
- ☐ Unemployed
- ☐ Medical Leave
- ☐ Disability
- ☐ Not employed
- ☐ Retired

Spiritual Practices
Do you participate in any form of meditation or introspective exercises?
☐ Yes ☐ No

Is prayer an important part of your life?
☐ Yes ☐ No

Anything you would like your practitioner to know about your faith? (Explain)

Nutrition (what type of foods do your regularly eat)

Soft Drinks/day _____
Caffeine Intake/day _____
Alcohol/month _____

Sleep (hours of sleep, sleep difficulty, sleep aids)

Exercise (What and how often)

Recent Major Life Events
- ☐ Loss/Change of job
- ☐ Move or relocation
- ☐ Death in family / close friend
- ☐ Diagnosis of new medical condition
- ☐ Traumatic physical/emotional event
- ☐ _____

Health Care Coordination - List all practitioners and healthcare providers (and type of therapy/treatment) you utilize as your health care team.

Referred by: _____
_____
_____
_____
_____