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Client History Form

Date:_____

Name:_____DOB_____

Address:_____
City _____State_____Zip_____

Telephone:
*Home:*_____*Work:*_____

E-mail address_____

How did you hear about our office?
_____

Personal History

Have you received prior treatment for your problem?_____

If yes, please explain the treatment received and by whom
_____

What techniques/ methods were used?
_____

How long have you received
treatments?_____Frequency:_____

Has treatment been discontinued?_____If yes, why?
_____

Please give a brief description of what you would like to accomplish or receive from your sessions:
_____

General Physical Trauma

Were you ever knocked unconscious?_____Have you ever broken any bones?_____

Have you ever had any impacts, falls, or jolts that you feel specifically have injured your
spine? _____If yes, please explain _____
_____

Have you had extensive dental work?_____Orthodontia?_____

If appropriate, provide additional explanation of symptoms on the preceding pages:
_____
_____

Please list any physical symptoms or issues that you currently have or have had in the past but were not mentioned on the preceding page:_____
_____

How do you grade your physical health? Excellent_____
Good_____Fair_____ Poor _____ Getting Better_____
Getting Worse_____
How is your physical health affecting your daily lifestyle and personal interactions?_____
_____
_____

Are you currently taking any prescription drugs? Yes_____ No_____
If yes, please list:
_____
_____
_____

Accidents

Have you ever been involved in a vehicular collision? Yes_____No_____
If yes, please list approximate dates and
severity_____
_____
_____

Food and Diet

Food	Daily	A few times a week	Weekly	Monthly	Never
alcohol					
artificial sweetener					
beef					
coffee					
cooked or canned vegetables					
dairy products					
diet food					
eggs					
fasting					
fish					
fried foods					
fruit					
organic foods					
poultry					
raw vegetables					
refined sugar					
seafood					
soda					
tobacco					
weight control diet					
whole grains					

The type of diet I usually follow is classified as:

_____

Are you currently taking any daily supplements? Yes____No_____
If yes, please list::

_____

Emotional Status

How do you grade your emotional/ mental health? Good____ Fair_____Poor_____
Getting Better ____ Getting Worse_____

How does your emotional/ mental health affect your daily lifestyle and personal interactions?

_____

	Present			Past		
	Mild	Moderate	Extreme	Mild	Moderate	Extreme
childhood stress						
school stress						
play or recreational stress						
family stress						
work related stress						
stress of commuting						
loss of a loved one						
change in lifestyle						
change in vocation						
abuse						
anxiety						
depression						
loss of balance						
scattered thinking						
fatigue						
insomnia- trouble getting to sleep						
insomnia-waking in the middle of the night						
oversleeping						
nervousness						
repressed anger						
painful experiences						
abandonment issues						

If appropriate, provide additional explanation of symptoms noted on previous page:
_____
_____
_____

Please list any other emotional symptoms or issues that were not mentioned on the preceding pages that you now have or have had in the past:
_____
_____
_____

Birth History

Was your delivery: Drug induced_____ "C" section_____
Breech_____ Prolonged_____Forceps or suction_____

Cord around neck _____ Other _____

Please provide additional significant birth history:
_____
_____
_____

Medical

Have you ever been hospitalized? Yes_____No_____ Or had surgery?_____

If yes to either question, what was actually done to you and/or what type of surgery did you
have?_____
_____
_____
_____

Do you still have all of your body parts/ organs? Yes_____ No_____

Do you wear glasses, bifocals, or contact lenses?_____

Thank you for taking the time to complete this client history form.