CLIENT HISTORY
(CONFIDENTIAL-for Practitioner´s use only)

Name _____ **Date** _____
Address _____
_____
Phone: Home_____ **Work** _____
E-mail_____ **D.O.B.** _____
Referred By _____**Occupation** _____
Relationship Status _____ **# Children**_____ **Height** _____ **Weight**_____
Reason for Visit _____
_____
Current Medications _____
Current Complementary Therapies / Supplements _____
Eating Habits / Diet _____
Amount Daily Intake: Water _____**Caffeine** _____ **Alcohol** _____**Cigarette / Tobacco** _____
Exercise Routine _____

Please mark the following areas of diseases or symptoms as 'C' for current, 'P' for past, and 'CH' for chronic. Explain if necessary.

EMOTIONAL / PSYCH	Hyperthyroid	Heart Attack	**URINARY**
Depression	Hypothyroid	Heart Failure	Bladder Infection
Eating Disorder	**NEUROLOGICAL**	Hypertension	Kidney Stones
Mood Swings	Epilepsy	Stroke	**REPRODUCTIVE**
Substance Abuse (type)	Dizziness	**RESPIRATORY**	Sex. Trans. Dis. (type)
AUTO-IMMUNE	Insomnia	Bronchitis	Endometriosis
AIDS / HIV	Migraines	Emphysema	Pregnancies (# & 'C')
Allergies	**MUSCULO-SKELETAL**	Pneumonia	Miscarriage (#)
Cancer	Arthritis	Tuberculosis	Abortion (#)
Fatigue	Back Pain	**DIGESTION**	
Fever (chronic)	Carpal Tunnel	Constipation (chronic)	
Fibromyalgia	Gout	Diabetes	**OTHER:**
Fungal Infections (type)	Skin Disorder (type)	Diarrhea (chronic)	
Herpes (type)	**E N T**	Gastritis	
Lyme Disease	Earaches (chronic)	Hepatitis	
Mononucleosis	Headaches	Hypoglycemia	
ENDOCRINE	Jaw Pain	Jaundice	
Adrenal Insuf.	**CARDIOVASCULAR**	Liver Disorder	
Pituitary Dysf.	Angina	Ulcers	

PLEASE CONTINUE.....

Please mark the following areas of diseases or symptoms as 'C' for current, 'P' for past, and 'CH' for chronic.

Crying spells	Change in sleep	Family problems	Angry outbursts	Loneliness
Relationship Problems	Increased nervousness	Eating changes	Social problems	Seeing things
Headaches	Work problems	Trouble concentrating	Sadness	Hearing things
Change in sexual activity	Suicidal	Feeling out of control	Homicidal	Unmotivated
Loss of trust in others	Financial problems	Panic attacks	Weight loss/ gain	
Forgetfulness	Violent feelings	Increased alcohol/ Drug use	Confusion	

Please list any traumatic or life threatening events that occurred in your life, and when they happened:

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What do you hope for and what are your expectations from this session and long- term?

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Is there anything else you want to share or want me to know?

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