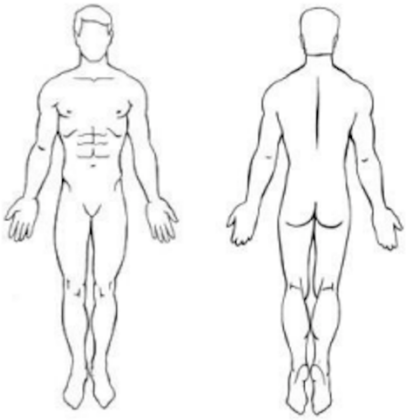
PROJECT WELLBEING

Client Health History Form

Name:_____ Date:_____
Address:_____ Referred By:_____
City/State/Zip:_____ Phone-Work:_____
Birthday:_____ Phone-Home:_____
Occupation:_____ Mobile:_____
Emergency Contact:_____ Email:_____

General Information

What is your main reason for coming to therapy_____
What specific goals would you like to achieve from therapy?_____
_____
How and when did the symptoms begin?_____
Where are your symptoms located? Please mark the areas on the figures below:



How long have you had these symptoms?_____
Are you currently, or have you ever been, under medical supervision for this problem/s?_____
_____
Have you had any tests for this problem; such as x-rays, MRI, or CT Scans? _____
Describe the symptoms. Please check all that apply:
☐ Dull ☐Ache ☐Burning ☐Sharp ☐Periodic ☐Constant ☐Sore ☐Stiff ☐Numb ☐Tingling
What makes it better or worse?_____
_____
On a scale of 0-10 with 10 being the most severe imaginable discomfort, what is your discomfort level right now?_____
What time of the day is the pain worse?_____
Do you have trouble sleeping? If yes, what position do you sleep in?_____

Physical Factors:

What physical activities are you currently involved in?_____
Do you stretch now?_____
Do you feel flexibility is an important part of fitness?_____
Have you ever had Chiropractic treatment? If yes, how long, how often and with whom?_____
_____
Have you ever seen a Naturopathic doctor?_____
Have you experienced any kind of bodywork before (i.e. massage, acupuncture, etc.)? If yes, what type?_____

Do you wear any type of supportive braces anywhere?_____
Do you wear orthotics?_____ If yes, for how long?_____
What percentage of your day is spent sitting?_____, standing?_____, driving?_____
Are your symptoms worse at the end of the workday?_____
Does your work station give you support and encourage good posture?_____
How would you rate your own posture?_____

Medical History

Please list any recent injuries, illnesses, or surgeries:_____
_____
_____
Are you currently under the care of a physician? Yes_____ No_____
If yes, please explain.
_____
List current medications, including aspirin, ibuprofen, etc. _____
_____
Please check all that apply

____ Cancer: Type _____
____ Digestion Problems
____ Circulatory Problems
____ Migraines/Headaches
____ Back Problems
____ Sciatica
____ Stroke
____ Scoliosis
____ Osteoporosis
____ Diabetes
____ Hi/Low Blood Pressure
____ Elimination Problems
____Respiratory Problems
____ Sinus Problems
____ Neck Problems
____Arthritis/Bursitis
____ Immune Disorder
____ TMJ
____ Tendonitis/Tendinosis
____ Now Pregnant
____ Epilepsy
____ Ulcers
____ Cold Hands/Feet
____ Heart Problems
____ Bruise Easily
____ Allergies
____ Fibromyalgia
____ Carpal Tunnel
____ Asthma
____ Immovable Joints

Do you have any chronic or frequent pain?_____
Have you had any accidents, auto or other?_____
Have you ever had any major surgeries?_____
Have you ever had a head injury?_____ Have you noticed dizziness?_____ Change in hearing?_____
Change in vision?_____
Are there any other medical conditions the therapist should be aware of?_____
Are you pregnant?_____ If yes, how far along are you?_____
Have you had, or are currently receiving cortisone/steroid shots?_____ If yes, when was the most recent one?_____

The above information is accurate and true to the best of my knowledge. If there are any changes in my current level of health, I will inform the person here that I'm seeing of my condition. I understand that this office does not diagnose or treat illness or disease and does not prescribe medications. I agree to pay my account with this office in accordance with the regular rates and payment terms. If, for any reason cancellation is necessary, I will give a 24-hour advanced notice. I understand that if I do not give this notice, I will be charged for the appointment unless it can be filled. Emergency cancellations will be determined by owner. It is agreed that any claim of liability is hereby waived.

_____ _____
Printed Name Date

_____
Signature