Barbara Solomon Healing LLC
New Client Information Form

Today's date _____

Name _____ Date of birth _____
Street address _____ City _____
Home phone number _____ May we leave messages here? Y __ N __
Alternate Phone # _____ May we leave messages here? Y __ N __
Emergency contact Name _____ Phone _____
Email address _____ May I contact you via email? Y __ N __
Referred by _____
Main reason for visit _____
Medications you are currently taking _____
_____ Allergies _____

Lifestyle Information

With whom do you live? Alone __ Partner/spouse __ Child(ren) __ Roommates __
Do you have any pets? Y __ N __ If so, what type(s)?_____
Do you work outside of the home? Y__ N __ Used to but now retired __
Please describe your job_____
# of hours per week you work ____ Time you get to play is enough ___ not enough ___
Typical diet _____
How much water do you drink daily? _____ Other types/amounts of fluids? _____
Type & amount of exercise per day or week _____

Review of Systems ~ Please place a "C" for current items that are a problem & a "P" for past/resolved problems.

Neurological

Headaches __ Numbness anywhere __ Stroke __ Red, dry or teary eyes __ Dizzy __
Poor night vision __ Ringing in ears __ Ears sensitive to cold __ Pain __
Other _____

Respiratory

Frequent colds __ Chronic nasal drainage __ Chronic cough __ Asthma __ COPD __
Shortness of breath with exertion __ Seasonal allergies __ Frequent bronchitis/pneumonia__
Other _____

Digestive

Poor or excessive appetite __ Teeth or gum problems __ Trouble swallowing __ Cramps __
Nausea or vomiting __ Heart burn __ Gas/bloating __ Belching __ Tired after eating __
Hard stools __ Constipation __ Diarrhea __ Frequency of bowel movements? _____
Other _____

Urinary

Trouble starting or stopping flow __ Burning while urinating __ Itch __ Dribbling __ Pain __
Other _____

Reproductive – Male

Impotence __ Prostate problems __ Low or excessive libido __
Other _____

Reproductive – Female

Irregular menstrual cycle __ PMS __ Painful intercourse __ (Peri)Menopausal __
Low or excessive Libido __ # of days of bleeding during period ___ Clots during period __
Typical color of menstrual blood on first day: Bright red __ Dark red __ Purple __
Typical color of menstrual blood on 3rd day: Bright red __ Dark red __ Purple __
Number of pregnancies _____ Number of live births ____
Other _____

Musculoskeletal

Muscle pain __ Joint Pain __ History of fractures __ Osteoporosis __ Osteoarthritis __
Rheumatoid Arthritis __ Bursitis __ Frequent sprains/strains __ Tendonitis __
Other _____

Cardiac

High blood pressure __ Coronary artery disease __ History of heart attack __ Pacemaker __
Irregular heart beats __ Palpitations __ Chest Pain __
Other _____

Endocrine/Other

Diabetes __ Thyroid problem __ Anemia __ Always feel cold/warm __ Dry or oily skin __
Frequent thirst __ Bruise easily __ Cold hands &/or feet __ Blood Dyscrasias __ Rash __
Other _____

Family Medical History – Are you adopted? Y ___ N___ If so, do you have bio-family medical information? Y___ N___

Please complete to the best of your knowledge:

	Mother	Father	Sibling#1	Sibling #2	Sibling #3
Is this person alive?	____	_____	_____	_____	_____
Current age or age at death	_____	_____	_____	_____	_____
Current health or cause of death	_____	_____	_____	_____	_____

Trouble falling asleep? _____ Trouble staying asleep? _____

Temperature assessment - If you are in a room full of others, will you be the 1st to take off your sweater, the last to take off your sweater or somewhere in the middle? _____

Do you have a tendency to get angry, frustrated and/or irritated easily? _____

Anything else I should know? _____
_____

Thank you

For Office Use

Client Name _____ Visit #1 Date _____

CC: _____

O: _____

P: _____

Q: _____

R: _____

S: _____

T: _____

A: R pulse: _____ L pulse: _____

Tongue:_____

Diagnosis:

P: Points: Needles Red Laser (635 Nm) Blue Laser (350 Nm) _____x ___ min

Needles Red Laser (635 Nm) Blue Laser (350 Nm) _____ x ___min

Needles Red Laser (635 Nm) Blue Laser (350 Nm) _____ x ___ min

Needles Red Laser (635 Nm) Blue Laser (350 Nm) _____ x ___ min

Needles Red Laser (635 Nm) Blue Laser (350 Nm) _____ x ___ min

Additional Tx: _____x ___ min

_____ x___ min

Response to Tx: _____

_____