Client History

Name_________________________________Date of visit______________________________
Address____

____
Date of Birth________________________Height________________Weight_________________
Occupation____________________Phone_________________email _______________________
Therapist (name, address, phone)____

____
Physician (name, address, phone) ____
Theraputic/Spiritual Growth Experience____
Reason for Visit____

____
Date of Onset______________ Sudden_____ Slow____
Previous Treatment____

____
Antibiotics/Medications Currently Taken____

____
Non-Medicinal Drugs Currently Taken____
Alcohol Intake______________Tobacco/Cigarettes____________Daily Fluid Intake____________
General Type of Diet____
Exercise____
Vision_____________Wear Glasses/Contacts___________Smell_______Hearing______Taste_______
Accidents/Injuries/Traumas____
Surgeries____

Do you have or have you had: (please mark "C" to indicate current and "P" for symptoms you have had in the past.)

Constipation ___	Ulcers___	Fever___	Kidney Problems___
Diarrhea___	Allergies___	Malaria___	AIDS___
Flatulence___	Eczema___	Mononucleosis___	Hypoglycemia___
Indigestion___	Psoriasis___	Tuberculosis___	Other__________________
Gastritis___	Dandruff___	Rheumatism___	
Dysentry___	Fungal Infections___	Arthritis___	
Dizziness___	Bronchitis___	Diabetes___	
Migraines___	Emphysema___	Herpes Simplex I___	
headaches___	Pleurisy___	Herpes Simplex II___	
Earaches___	Pneumonia___	Gonorrhea___	
Jaw Pain___	Chicken Pox___	Heart Disease___	
Back Pain___	Measles___	Cancer___	
Hypertension___	Mumps___	Epilepsy___	
Depression___	Whooping Cough___	Stroke___	
Mood Swings___	Jaundice___	Female Organ Problems___	
Insomnia___	Rheumatic fever___	Pancreas Problems___	
Fatigue___	Syphilis____	Liver Problems___	

What are your goals/expectations from this healing today/long term?
____

____
Is there anything else you would like me to know?
____