



Client Health History

| NameDa | te of First Appointment |
|---|-------------------------------|
| Address | |
| Home phone | Cell/work phone |
| Emergency contact | phone number |
| Gender Identifying | Your age |
| Your Occupation | |
| Marital status If not married, do you h | ave a significant other? |
| Children? | Ages |
| Date of birth | e-mail address |
| What alternative therapies have you experienced? | |
| How long ago? | Frequency? |
| Do you stretch? | How often? |
| Do you exercise regularly or participate in sports? | What?How often? |
| What is your current stress level? | Anxiousness: |
| (low) 1 2 3 4 5 (high) | Often Sometimes Seldom |
| Is the stress: | Depression: |
| positive negative both | Often Sometimes Seldom |
| How many hours do you sleep each night? | |
| Do you usually wake feeling: | |
| rested tired other | |
| What is your major area of pain and/or concern? | When did you first notice it? |
| What brought it on?Wha | t activities aggravate it? |
| Is this condition getting worse? | |
| Does it interfere with: work sleep recreation | |
| At or around the time of the onset were there emotional | stresses occurring? |
| What do you believe is wrong with you? | |
| What have you done to get relief? | |
| Have you sought a diagnosis? | Diagnosis |
| By whom? | |
| Other areas of pain and/or concern | |

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Client Health History



DIGESTION AND DIET

| Typical breakfast | | lunch | |
|-------------------------------|------------------------------|--|-------------------------|
| dinner | | snacks | |
| How many meals per week | do you eat fast food, takeo | out, or dine out? | |
| How many times per week | do you have: | | |
| beef | chicken | fish | pork |
| white bread | white rice | crackers, chips,pretzels | cow milk |
| ice cream | cheese | other dairy | desserts |
| canned food | soda pop | | |
| Do you add salt to your food | l?What wo | ould you say is the worst thing yo | ou eat? |
| Indicate the following habi | ts with the applicable lette | r: H -heavy M -moderate L -ligh | ht N-none |
| Alcohol Coffee T | ea Colas Tobaco | co Marijuana other | |
| How much WATER do you d | lrink per day? | | |
| Are you subject to stress or | binge eating? | On what foods? | |
| What food do you find to be | your weakness? | | |
| Appetite (check one) GOOD | FAIR POOR | | |
| Digestion (check one) GOO | D FAIR POOR _ | | |
| Do you experience bloating | /gas after meals? | Do you have sour burps? | heartburn? |
| Do you feel SLEEPY after m | neals? | If so, how often? | |
| Are you on a restricted die | t? | | |
| Please explain | | | |
| How often do you have a BC | OWEL movement? | Do yo | ur stools:sinkfloatboth |
| Have you ever had: hard st | ools? how often? | _ loose stools?how often? | |
| URINATION (check all that | apply) | | |
| Normal Scanty | More Than 5xs Dail | y Burning Strong Oc | dor Dark Color |
| Typical COLOR | | | |
| Is there any history of blade | der or kidney infections? | | If so, at what age? |

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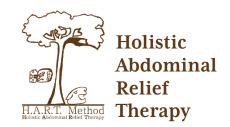


FAMILY HISTORY

| Is family history known? | | | | |
|-------------------------------|----------------|------------------------|-------------------------|--------------------------------|
| Please list: 1. Alive? 2. Age | 2/Cause of Dea | th 3. Major ailments w | hile alive | |
| MOTHER | 1 | 2 | 3 | |
| Maternal Grandmother | 1 | 2 | 3 | |
| Maternal Grandfather | 1 | 2 | 3 | |
| FATHER | 1 | 2 | 3 | |
| Paternal Grandmother | 1 | 2 | 3 | |
| Paternal Grandfather | 1 | 2 | 3 | |
| (OPTIONAL) Is there a hi | story of abus | e in your family? | (circle one) emotion | nal physical sexual spiritua |
| EMOTIONAL AND SPIR | ITUAL | | | |
| If romantically involved, | how is your | relationship? | Is your love life satis | sfying? |
| If possible, please explain | the negative | e emotion you experi | ence most | |
| | | | | |
| | | | | |
| | | | | |
| Do you pray? | | If so, h | ow often? | |
| Do you meditate? | | If so, h | ow often? | |
| Rate yourself: N - none | S - some I | L - lots | | |
| Faith Hope | _ Charity_ | Generosity | Sense of humor | Sense of fun |
| Is there an unrealized lo | nging in you | r life? If so, wh | at is it? | |
| Are you involved in activ | ities outside | of work? If so, | what type? | |
| Hobbies and/or interests | • | | | |

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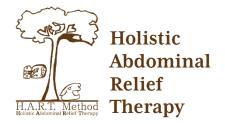


BIRTH AND EARLY CHILDHOOD

| My birth was: (check one)NormalDifficultUnknown Please explain |
|---|
| T lease explain |
| Briefly explain your early relationship with each of your parents |
| |
| Briefly explain your present relationship with each of your parents |
| MEDICAL HISTORY |
| What is your blood type? (A, AB, B, 0) |
| |
| Are you currently under the care of a doctor, chiropractor or other health care practitioner? |
| |
| Name of practitioner/clinic |
| City State Phone List any medications you are taking |
| |
| For how long? Do you have allergies? |
| Previous broken bones including year |
| Previous accidents including year |
| Previous surgeries including year |
| Other hospitalizations including year |
| Childhood accidents or physical traumas |
| List any medications you took as a child and how long taken |
| Have you ever hit or fallen on your head or tailbone? Did you suffer trauma at birth? |
| Did you or have you ever had an inguinal hernia or surgery for an inguinal hernia? |
| Please explain |
| |
| Did you or have you ever had a hiatal hernia? |
| Please explain |
| |

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Mark *current* problems with a "C" mark *past* problems with a "P"

| C | P | | C | P | | C | P | |
|---|---|--|---|---|-------------------------------------|---|---|----------------------------|
| | | headaches | | | asthma | | | contact lenses or dentures |
| | | constipation | | | allergies | | | fatigue |
| | | arthritis, osteoporosis, brittle bones | | | pregnancy | | | diabetes |
| | | hepatitis | | | varicose veins/circulatory problems | | | cold hands |
| | | swollen ankles | | | sinus trouble | | | heart pain |
| | | cold feet | | | painful joints | | | swollen joints |
| | | face flushed | | | tightness in shoulder blades | | | fainting spells |
| | | emotional problems | | | anorexia/bulimia | | | heart problems |
| | | kidney problems | | | bad breath | | | ringing in ears |
| | | tightness in throat | | | loss of smell | | | loss of taste |
| | | muscle spasms in neck | | | grating in neck | | | blood clots/phlebitis |
| | | loss of memory | | | frequent cold or flu | | | numb hands or feet |
| | | head feels too heavy | | | pinched nerve in back | | | herniated or bulging disc |
| | | epilepsy or other seizures | | | pains in legs and feet | | | shooting pain in head |
| | | high or low blood pressure | | | spinal problems | | | pins & needles in legs |
| | | pins & needles in back | | | pins & needles in arms and hands | | | sciatica |
| | | painful menstruation/cramps | | | lung or breathing problems | | | cancer |
| | | skin disorders, acne, fungus, rash | | | sensitivity to oils and lotions | | | depression |

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Please read and sign.

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I agree to give at least 24-hours notice of cancellation of an appointment. cases of extreme emergency are considered exceptions to this cancellation policy.

I understand the treatment here is not a replacement for medical care. I understand the therapist does not diagnose medical illness, disease, or any other physical or mental condition. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. I understand that the treatment is not a substitute for medical treatments and/or diagnosis and it is recommended that I see a qualified professional for any physical or mental conditions that I may have. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my health.

| Client signature | Date | |
|------------------|------|--|

Certified H.A.R.T. Method Practitioner Therapeutic Massage Shiatsu Thai Massage karen@callkaren.org (612) 644 2468

www.callkaren.org