**When completed, email your form to Sarah. Reply to your appointment confirmation email.**

**Client History Form**

|  |  |
| --- | --- |
| Name: | Email: |
| Address: | City, State, Zip: |
| Home Phone: | Other Phone: |
| Cellular Phone: | Referred by: |
| Date: | Date of Birth: |

**Part 1. General Health**

Describe the problem(s) for which you seek help.

Click or tap here to enter text.

Describe past medical history (previous injuries, accidents, surgeries, illnesses, etc.). Include approximate dates.

Click or tap here to enter text.

Have you ever been the victim of abuse or neglect?

Click or tap here to enter text.

Please list and describe any stresses in your life.

Click or tap here to enter text.

|  |  |
| --- | --- |
| Please select the level of stress for the below listings: none, minimal, moderate, severe. | |
| My family stress is: | Choose an item. |
| My relationship stress is: | Choose an item. |
| My work stress is: | Choose an item. |
| My financial stress is: | Choose an item. |
| My health stress is: | Choose an item. |
| Other stress is: | Choose an item. |

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, prayer, gardening, etc.?

Click or tap here to enter text.

How many hours a night do you sleep? Click or tap here to enter text.

Is your sleep restful? If not, please explain:

Click or tap here to enter text.

Describe your typical diet (foods you eat, foods you avoid, foods you crave, etc.):

Click or tap here to enter text.

**Part 2. Family & Childhood**

In a few sentences, describe your relationship with your mother during your childhood (from your perspective).

Click or tap here to enter text.

In a few sentences, describe your relationship with your father during your childhood (from your perspective).

Click or tap here to enter text.

In a few sentences, describe what it was like to grow up in your family.

Click or tap here to enter text.

List any significant traumas from your past (premature birth, car accidents, divorce, abuse, mental illness, etc.):

Click or tap here to enter text.

If applicable, please describe any pregnancies, miscarriages, infant loss, pregnancy termination, or live births and any stress or trauma around these:

Click or tap here to enter text.

**Part 3. Recent Emotions**

|  |  |  |  |
| --- | --- | --- | --- |
| Please check any of the following feelings you have experienced in the last few months. | | | |
| Abused | Paranoid | Unable to grieve | Panic |
| Criticized | Overwhelmed | Apprehensive | Intolerant |
| Overworked | Muddled | Agitated | Uncertainty |
| Paralyzed | Persecuted | Uneasy | Aggravated |
| Depressed | Guilty | Distress | Annoyed |
| Rejected | Easily irritated | Fearful | Angry |
| Despair | Anxious | Impatient | Outraged |
| Helpless | Sad | Intimidated | Nervous |
| Hopeless | Grieving | Restless | Worried |

**Part 3. Pain**

Please list any areas of pain or discomfort in the body. Rate each area according to the scale below and list details, if necessary.

Rating:

1. Slightly aware of discomfort

2-3. Aware of discomfort as an aggravation

4-6. Pain is strong but you are still functional

7-9. Pain is so strong you are unable to function normally

10. You feel like you need to go to emergency room

Areas of pain and discomfort:

Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date form completed: Click or tap here to enter text.