**Client History Form**

|  |  |
| --- | --- |
| Name: Click here to enter text. | Email: Click here to enter text. |
| Address: Click here to enter text. | City, State, Zip: Click here to enter text. |
| Home Phone: Click here to enter text. | Other Phone: Click here to enter text. |
| Cellular Phone: Click here to enter text. | Referred by: Click here to enter text. |
| Date: Click here to enter text. | Date of Birth: Click here to enter text. |

**Part 1. General Health**

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

Click here to enter text.

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

Click here to enter text.

Have you ever been the victim of abuse or neglect?

Click here to enter text.

Please list and describe any stresses in your life.

Click here to enter text.

|  |  |
| --- | --- |
| Please select the level of stress for the below listings from the drop down menu. | |
| 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, etc.?

Click here to enter text.

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

Is your sleep restful? Click here to enter text.

If not, please explain: Click here to enter text.

Describe your typical diet (foods you eat, foods you avoid, foods you crave, etc.): Click 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 here to enter text.

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

Click here to enter text.

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

Click here to enter text.

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

Click 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 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 here to enter text.

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Date form completed: Click here to enter a date.

Person completing form: Click here to enter text.