

**NEW CLIENT INFORMATION - Short Version**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_ Date \_\_\_\_\_  
Name you prefer \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
Email Address: \_\_\_\_\_ Ages of Children \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work hrs/week \_\_\_\_  
Spouse or Partner's Name \_\_\_\_\_ Their Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship to you \_\_\_\_\_  
Hm Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_  
How did you hear about me? \_\_\_\_\_  
Circle if any previous experience with: *Chiropractic* *Massage* *CranioSacral* *Energy Work* *Herbs*  
*Acupuncture/Pressure* *Other Natural Health Care* \_\_\_\_\_

**Briefly list your main health concerns, numbering them by importance to you (1 = most important).**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Accidents or Injuries you've had in the past** (hard falls, auto/bike accidents, etc.) showing approx Mo/Yr.

**Surgeries or Hospitalizations:**

**Please list any medications or non-prescription drugs that you use currently & how often:**

**Do you feel stress in your life at home?** *None* *Mild* *Moderate* *Severe* ***If yes, please describe:***

**At work?** *None* *Mild* *Moderate* *Severe* ***If yes, please describe:***

**Extended Family?** *None* *Mild* *Moderate* *Severe* ***If yes, please describe:***

**Please circle your water sources for drinking and cooking:** *city tap* *filtered (brand: \_\_\_\_\_ )*  
*distilled* *well* *reverse osmosis* *glass bottled* *plastic bottled* *Other: \_\_\_\_\_*

**Family History:** *If any of your immediate family has had problems with any of the following, please use this key to indicate which family member after the condition: I=myself, GF/GM=grandfather/mother, F=father, M=mother, B=brother, S=sister, C=child. Use "2B" to indicate two brothers with the same condition, etc.*

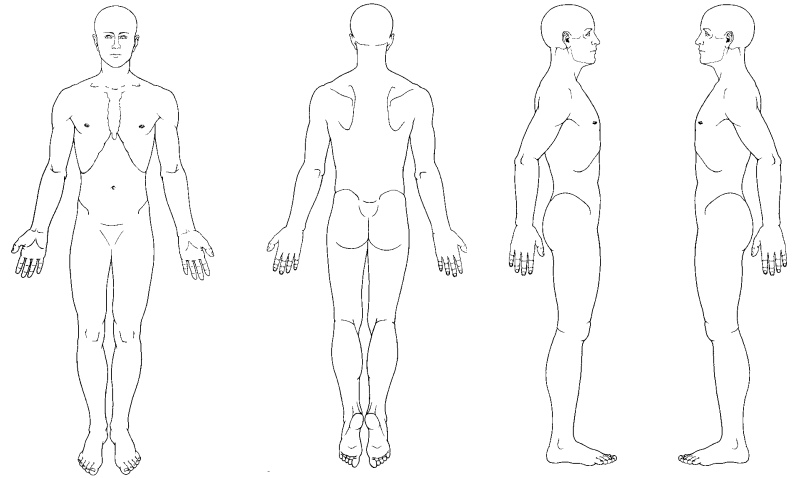
- |             |                   |                     |                  |
|-------------|-------------------|---------------------|------------------|
| Addiction   | Cancer            | Headaches - regular | Parasites        |
| Allergies   | Constipation      | Headaches-migraine  | Reproductive     |
| Alzheimer's | Depression        | Heart Disease       | Sinus            |
| Anger       | Dementia          | Hi Blood Pressure   | Stress - tension |
| Anxiety     | Diabetes          | Insomnia            | Stomach          |
| Arthritis   | (or Pre-Diabetes) | Intestinal          | Thyroid          |
| Asthma      | Emphysema         | Kidney              | Ulcers           |
| AutoImmune  | Epilepsy          | Liver Problems      | Weight           |
| Bowel-colon | Fatigue           | Menstrual Pain      | <i>Other</i>     |

**Circle your Blood Type, if known: A B AB O**

**Please list any known allergies or sensitivities & what you do to manage or prevent the symptoms:**

Primary Concern: \_\_\_\_\_

**Instructions:** Please shade in your areas of discomfort (or other symptoms). Use one of these sheets for each of your main concerns. *If all your various concerns began at the same time and behave in the same way, you can put them all on a single form. Otherwise, please fill out a separate Chief Concern form for each issue.*



**Onset**

When did you first notice this?

It came on: *Suddenly* *Gradually*

What were you doing at the time, or what do you think caused it? If injury, describe specifically how it happened, where the impact was, etc:

Since onset, overall it has gotten: *Better* *Worse* *Stayed the same* *Gone up & down* *Other*

**Pain Characteristics**

Describe what it feels like: *Sharp* *Dull* *Achy* *Throbbing* *Burning* *Numb* *Tingling* *Other:*

Grade: How would you rate the intensity on this scale? *Draw an oval to depict the range from best to worst, and place an "X" where it is most of the time:* *No Problem* | - - - - - | *Severe*

How often do you feel this? (*Use an X*) *Never* | - - - - - | *Constant*

List any time of day, season, or other cycle when it's worse:

List any timing when it's better:

Radiation: Does the sensation seem to spread out, or "travel" to another area? *Yes* *No*

If Yes, indicate this on the drawing above with an arrow, showing where it starts, and where it spreads to.

List anything you do that makes it better:

List anything you do that makes it worse:

Does it feel better when you lie down & rest? *Yes* *No* Does it affect your sleep? *Yes* *No*

Does this problem limit any of your regular activities? *Yes* *No* Please describe:

**Other Practitioners you have seen for this problem:**

1. \_\_\_\_\_ Their Opinion & Rcmmd: \_\_\_\_\_

2. \_\_\_\_\_ Their Opinion & Rcmmd: \_\_\_\_\_

**Have you had similar symptoms in the past?** *Yes* *No* If yes, please give approximate timing and describe circumstance or relation to major events (e.g. mo/year it occurred, shortly after my divorce, etc):

**Have you had any injuries to this area in the past?** *Yes* *No* If yes, please describe circumstance and give approximate date:

**Anything else I should know?**