**NEW CLIENT INFORMATION & GENERAL HISTORY**

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). Please fill out a "Chief Concern" sheet for each one (unless they started together & behave the same).**

1.
2.
3.

**What are your goals regarding your health & well being for the:**

**Short term (next 2-3 months)?**

1.
2.
3.

**Long Term (next few years)?**

1.
2.
3.

Please indicate your level of commitment to reaching these goals (X): *Weak* | - - - - - - - - - - | *Strong*

***PLEASE NOTE: We do not treat any specific disease states. Our focus is on supporting your body to return to balance, to the extent possible, so that it can heal what is possible for it to heal. Results cannot be guaranteed, but we will do our best to help you achieve a better state of health. We are a team - your participation and commitment are necessary ingredients to achieve your health goals!***

**Accidents or Injuries you've had in the past** (hard falls, auto/bike accidents, etc.) ***Any Scars?***

1. Mo/yr _____ Incident ____________________________________________________ *Y* *N*
2. Mo/yr _____ Incident ____________________________________________________ *Y* *N*
3. Mo/yr _____ Incident ____________________________________________________ *Y* *N*
4. Mo/yr _____ Incident ____________________________________________________ *Y* *N*

**Surgeries or Hospitalizations**

1. Mo/yr _____ Condition ___________________________________________________ *Y* *N*
2. Mo/yr _____ Condition ___________________________________________________ *Y* *N*
3. Mo/yr _____ Condition ___________________________________________________ *Y* *N*

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

**Medications you've used in the past, for a year or more:**

**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:***

 Date ______________ Name ________________________________

- This is a list of actions or choices that tend to either detract from your health or support it. To indicate how often you do something on the list, *fill in the blank with appropriate number (including 0), and* ***circle*** *appropriate time span (day, week or month).*

| ***Better to Reduce or Eliminate:*** | | ***Better to Include More of:*** | |
|---|---|---|---|
| Packaged food products | ___x per day wk mo | Pure Water (#of glasses) | ___x per day wk mo |
| Alcohol | ___x per day wk mo | Herb teas (w/o caffeine) | ___x per day wk mo |
| Cigarettes/Tobacco | ___x per day wk mo | Olive Oil (extra virgin) | ___x per day wk mo |
| Coffee | ___x per day wk mo | Organic/Natural Poultry | ___x per day wk mo |
| Other Drugs | ___x per day wk mo | Organic/Nat Red Meat | ___x per day wk mo |
| Regular Soft Drinks | ___x per day wk mo | Organic/Natural Eggs | ___x per day wk mo |
| Diet Soft Drinks | ___x per day wk mo | Small Cold-Water Fish | ___x per day wk mo |
| Sweets/Pastries | ___x per day wk mo | Fruit (raw, organic) | ___x per day wk mo |
| Artificial Sweeteners | ___x per day wk mo | Veges (fresh organic) | ___x per day wk mo |
| Fast foods | ___x per day wk mo | Whole Grains | ___x per day wk mo |
| Restaurant food | ___x per day wk mo | Legumes: beans, lentils | ___x per day wk mo |
| Margarine or Crisco | ___x per day wk mo | Raw nuts or seeds | ___x per day wk mo |
| Light vegetable oils | ___x per day wk mo | Multi Vit/Mineral | ___x per day wk mo |
| Regular Red Meat | ___x per day wk mo | Anti Oxidant formula | ___x per day wk mo |
| Regular Poultry | ___x per day wk mo | *Restful sleep* | ___ *hours per night, avg* |
| Regular Eggs | ___x per day wk mo | *Rest/Relaxation* | ___*min / day wk mo* |
| Cow's Milk Products | ___x per day wk mo | *Doing what I love* | ___*min / day wk mo* |
| Tuna (Lg predatory fish) | ___x per day wk mo | *Prayer/Meditation* | ___*min / day wk mo* |
| *Worrying* | ___*x per day wk mo* | *Regular exercise* | ___*min / day wk mo* |
| *Criticizing myself* | ___*x per day wk mo* | *Affirmation/Visualization* | ___*min / day wk mo* |
| *Over-work* | ___*x per day wk mo* | *Journal writing* | ___*min / day wk mo* |
| *Feeling angry* | ___*x per day wk mo* | *Support/Nurture others* | ___*x per day wk mo* |
| *Stuffing my feelings* | ___*x per day wk mo* | *Receive support/nurture* | ___*x per day wk mo* |
| *Not speaking out* | ___*x per day wk mo* | *Asking for what you need* | ___*x per day wk mo* |

**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 | *Other* |

**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:**

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