

## CLIENT HEALTH HISTORY

Name \_\_\_\_\_ DATE of First Appointment \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell/work phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ & phone number \_\_\_\_\_

How did you hear about Adagio Holistic Therapies, LLC? \_\_\_\_\_

Gender **M** or **F** Your age \_\_\_\_\_ Your Occupation \_\_\_\_\_

Marital status \_\_\_\_\_ If not married, do you have 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? (low) 1 2 3 4 5 (high) Is the stress: positive or negative or both?

How many hours do you sleep each night? \_\_\_\_\_ Do you usually wake feeling: rested? tired? other? \_\_\_\_\_

ANXIOUSNESS: **Often** **Sometimes** **Seldom** DEPRESSION: **Often** **Sometimes** **Seldom**

What is your major area of pain and/or concern? \_\_\_\_\_

When did you first notice it? \_\_\_\_\_ What brought it on? \_\_\_\_\_

What 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 \_\_\_\_\_

FOR OFFICE USE ONLY:

FERT. ABO. TCM. HYPN. PREG. CONC. MISC. BRTH. BRCH.

*Digestion and Diet*

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Typical breakfast \_\_\_\_\_ lunch \_\_\_\_\_  
dinner \_\_\_\_\_ snacks \_\_\_\_\_

How many meals per week do you eat fast food, takeout, 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? \_\_\_\_\_ What would you say is the worst thing you eat? \_\_\_\_\_

Indicate the following habits with the applicable letter: **H**-heavy **M**-moderate **L**-light **N**-none

Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ Colas \_\_\_\_\_ Tobacco \_\_\_\_\_ Marijuana \_\_\_\_\_ other \_\_\_\_\_

How much WATER do you drink per day? \_\_\_\_\_

Are you subject to binge eating? \_\_\_\_\_ On what foods? \_\_\_\_\_

What food do you find to be your weakness? \_\_\_\_\_

Appetite (circle one) GOOD FAIR POOR Digestion (circle one) GOOD FAIR POOR

Do you experience bloating/gas after meals? \_\_\_\_\_ Do you have sour burps? \_\_\_\_\_ heartburn? \_\_\_\_\_

Do you feel SLEEPY after meals? \_\_\_\_\_ If so, how often? \_\_\_\_\_

Are you on a restricted diet? \_\_\_\_\_ Please explain \_\_\_\_\_

How often do you have a BOWEL movement? \_\_\_\_\_ Do your stools: **sink** or **float** or **both** ?

Have you ever had: hard stools? \_\_\_\_\_ how often? \_\_\_\_\_ loose stools? \_\_\_\_\_ how often? \_\_\_\_\_

URINATION (circle as applicable)

NORMAL SCANTY More than 5 times daily BURNING STRONG ODOR DARK COLOR

Typical COLOR \_\_\_\_\_

Is there any history of bladder or kidney infections? \_\_\_\_\_ If so, at what age? \_\_\_\_\_

*Family History*

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	Alive?	Age/Cause of Death	Major ailments while alive
MOTHER	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
FATHER	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____

(OPTIONAL) Is there a history of abuse in your family? \_\_\_\_\_ (circle) emotional physical sexual spiritual

Is there a history of: drug abuse alcohol abuse suicide in your family? (Please circle as applicable.)

*Emotional and Spiritual*

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If romantically involved, how is your relationship? \_\_\_\_\_ Is your love life satisfying? \_\_\_\_\_

Were/are there any emotional traumas in your early or present life? (ie. rape, great loss, suicide, death of a loved one, etc.) \_\_\_\_\_

If possible, please explain the negative emotion you experience most \_\_\_\_\_

**When** do you most often feel this emotion? \_\_\_\_\_

**Where** are you when you feel this emotion? \_\_\_\_\_

What is your opinion of yourself? \_\_\_\_\_

Have you ever been to counseling? \_\_\_\_\_ If so, what was the outcome? \_\_\_\_\_

Do you pray? \_\_\_\_\_ If so, how often? \_\_\_\_\_ Do you meditate? \_\_\_\_\_ If so, how often? \_\_\_\_\_

RATE Yourself: **N** – none **S** – some **L** – lots

Faith\_\_\_\_ Hope\_\_\_\_ Charity\_\_\_\_ Generosity\_\_\_\_ Sense of humor\_\_\_\_ Sense of fun\_\_\_\_

Is there an unrealized longing in your life? \_\_\_\_\_ If so, what is it? \_\_\_\_\_

Are you involved in activities outside of work? \_\_\_\_\_ If so, what type? \_\_\_\_\_

Hobbies and/or interests \_\_\_\_\_

*Birth and Early Childhood*

My birth was: (circle one) Normal Difficult Unknown

Please 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, O) \_\_\_\_\_

Are you currently under the care of a doctor, chiropractor or other health care practitioner? \_\_\_\_\_

If so, for what condition? \_\_\_\_\_

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? \_\_\_\_\_

Do you or have you ever had an **inguinal hernia** or surgery for an inguinal hernia? \_\_\_\_\_

Please explain \_\_\_\_\_

Do you or have you ever had a **hiatal hernia**? \_\_\_\_\_ Explain \_\_\_\_\_

CIRCLE any of the following you are CURRENTLY experiencing.

Underline any you have had as a Past problem.

headaches	asthma	contact lenses or dentures	constipation
allergies	fatigue	arthritis, osteoporosis, brittle bones	pregnancy
diabetes	hepatitis	varicose veins/other circulatory problems	cold hands
swollen ankles	sinus trouble	heart pain	cold feet
painful joints	swollen joints	face flushed	tightness in shoulder muscles
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

*Please read and sign.*

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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 conditions. 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 \_\_\_\_\_