ADAGIO HOLISTIC THERAPIES, LLC

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

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

	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

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.

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I agree to give at least 48 business hours' notice (2 full business days) 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 _____