INSIGHT BODY THERAPIES

CLIENT INFORMATION (kept confidential)

Name: Date:
Address, including zip: email address:

Daytime phone: Evening phone:
Emergency contact and phone:

Date of Birth: Age:

Marital Status:
[] Single [] Married [] Living with [] Widowed [] Separated [] Divorced

Number of children: Occupation:
Hobbies/Recreation:
By whom were you referred?

List all physical complaints:

Briefly describe the health concern(s) you would like to address in this session. Note when it began, and if there was any trauma at the onset. Rate the severity on a scale of 0 (nonexistent) to 10 (all time worst).

What do you feel caused this problem?

What other approaches have you tried for the problem(s) and how well did they work?

Are you currently in a course of treatment (doctor, chiropractor, acupuncturist, massage,etc.)?

List history of accidents, injuries, surgeries, major illness (with dates):

Are you currently taking cholesterol lowering (statin) drugs?
List medications taken and what they're for:

Please list any chronic condition-- headaches, indigestion, insomnia, allergies, etc.:

Please list your supplements:

What is your daily intake of:
Pure water? ______ 8-oz glasses Fruit juice? ______ Soft drinks? ______
Tea/coffee? ______ cups Alcohol? ______

Briefly describe your diet:

Bowel movements: ____ times/day ____ times/week
Approximate diameter of stool:

How often do you exercise?
[] daily [] weekly [] occasionally [] never

What types of exercise do you engage in?

On a scale of 1-10 what is your daily vitality?

Do you experience any physical pain you haven't already mentioned? If yes, explain.

Check if you experience:
[] ringing in the ears [] jaw clicking/popping [] facial pain

Check if you have:
Orthotic appliances (corrective inlays) in your shoes ____
Breast implants____ Pectoral implants____ Calf implants____
Medical devices implanted_____ Where?

Had any jaw surgery on, or alteration of the temporal-mandibular joint (jaw hinge)____

Have you:
Had hip replacement: R___ L___ Both___ When?
Had knee replacement: R___ L___ Both___ When?
Fallen on your tailbone ____ When?
Had a lymph node removed ___ When and where?

Do you have skin sensitivity to any substances? List:

Do you have food allergies, seasonal or other allergies? List:

Are you pregnant? [] yes [] no If yes, how many months? ________

Is your menstrual cycle: [] regular [] irregular [] painful [] heavy
Are you: [] menopausal [] other: ______________________________________

Have you, currently or in the past, had a cancer diagnosis? [] yes [] no
If yes, are you [] at diagnosis [] in treatment [] post treatment [] in maintenance
If currently undergoing chemotherapy, has your doctor told you that your chemo could affect others?
If currently undergoing radiation, is the radiation internal or external?
If internal, where and when was it placed?
Were lymph nodes biopsied or removed?
If yes, where and how many?

Please describe your diagnosis and treatment to date: