New Client Health Information – Please PRINT clearly

Last Name: _____ First Name: _____ Age: ____

Today's Date: _____ Email: _____

Address: _____ City/Zip: _____

Phone: _____

What is your primary reason or health goal for scheduling this session?

_____

What is your current level of stress? ☐ Low ☐ Medium ☐ High ☐ Very High

Health Overview: Mark "X" next to any health conditions you have had

X	HEALTH CONDITION	DESCRIPTION / ADDITIONAL INFORMATION
	A.D.D / A.D.H.D.	
	Adrenal Exhaustion / Chronic Fatigue	
	Anemia	
	Angina	
	Anxiety ☐ More Recent OR ☐ Life-Long	
	Arthritis ☐ Osteo ☐ Rheumatoid	
	Asthma	
	Autoimmune Disease	
	Bi-Polar Disorder	
	Blood Pressure – ☐ HIGH, under control ☐ LOW	
	Cancer ☐ In treatment now ☐ Post treatment	• Type of Cancer: • Year of Diagnosis:
	Carpal Tunnel	
	Carotid Artery Disease	
	Chronic Pain • Average level of pain is _____	• Area(s) of pain:
	COPD	
	COVID 19 – *Experiencing Post COVID Symptoms*	
	Depression ☐ More Recent OR ☐ Life-Long	
	Diabetes	

	Digestive Issues	
	Dizziness / Vertigo	
	Glaucoma	
	Heart Disease	
	Headaches – Migraines	
	Hearing Problems	
	Hiatal Hernia	
	History or Physical, Emotional or Sexual Abuse	
	History of ☐Congestive Heart Failure or ☐Stroke	
	IBD ☐ Constipation ☐ Diarrhea	
	Insomnia ☐ More recent OR ☐ Long-term	
	Joint Replacement(s):	• Which joints?
	Lymphedema	• Which areas?
	Narcolepsy	
	Neuropathy	
	Neurological Disorder	• Which disorder?
	☐ Osteoporosis OR ☐ Osteopenia	
	☐ Pacemaker ☐Other Implanted Medical Device	
	Post-Traumatic Stress Disorder (PTSD)	
	Reproductive System Issues (such as POCS)	
	Scoliosis ☐ C Curve ☐ S Curve **OR** ☐ Kyphosis	
	Thyroid Condition ☐ Hyper ☐ Hypo	
	Viral Disease ☐ AIDS / HIV ☐ Herpes ☐ Hepatitis ☐ Meningitis ☐ Polio	

Note any Injuries/Accidents:

Note any Surgeries:

List conditions that you are taking medications for: