NEW CLIENT INFORMATION & GENERAL HISTORY

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Name ____________________________________ Birth Date _________ Age ____ Date ____________
Name you prefer ___________________________ Home Phone ____________ Cell 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, in order of their 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 or intentions regarding your health & well being for the:

Short term (next 6 months)?	Long Term (next five years)?
1.	1.
2.	2.
3.	3.

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

We do not treat specific disease states. We focus on helping you clear the hidden blocks to healing and on supporting your body to return to balance. Then your body 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:***

General History - Pg 2 of 2 Date ______________ Name ____________________________________

Here 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 Meat	___x per day wk mo
Other Drugs	___x per day wk mo	Organic/Natural Poultry	___x per day wk mo
Soft Drinks	___x per day wk mo	Organic/Natural Eggs	___x per day wk mo
Sweets/Pastries	___x per day wk mo	Cold water fish	___x per day wk mo
Artificial Sweeteners	___x per day wk mo	Fruit (raw)	___x per day wk mo
Fast foods	___x per day wk mo	Fresh vegetables	___x per day wk mo
Restaurant food	___x per day wk mo	Organic Whole Grains	___x per day wk mo
Margarine or Crisco	___x per day wk mo	Legumes: beans, lentils	___x per day wk mo
Light vegetable oils	___x per day wk mo	Raw nuts or seeds	___x per day wk mo
Regular Red Meat	___x per day wk mo	*Restful sleep*	___ *hours per night, avg*
Regular Poultry	___x per day wk mo	*Rest/Relaxation*	___*min / day wk mo*
Regular Eggs	___x per day wk mo	*Doing what I love*	___*min / day wk mo*
Regular Milk Products	___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*	*Honest self-expression*	___*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:* ________________________

Electromagnetic: How far do you live/work from nearest cell ph tower? __ mi Elect power Station? __ mi

Microwave Oven ___ min/day Blue Tooth ___ min/day Wireless equip (router, mouse,

Cell Phone ___ min/day Computer ___ hrs/day keybd): turned on ___ hrs/day

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.

ADD/ADHD	Candida	Headaches - regular	Mind/Memory
Addiction	Chron's disease	Headaches - migraine	PMS/Menstrual Pain
Allergies	Constipation	Heart Disease	Parasites
Alzheimer's	Depression	Hi Blood Pressure	Reproductive probs
Anger	Diabetes	Infections-frequent	Sinus
Anxiety	Digestive trouble	Insomnia	Stress - tension
Arthritis	Dementia	Inflammatory Bowel	Stomach
Asthma	Emphysema	Kidney	Thyroid
Autoimmune	Epilepsy	Liver (mono, hep etc)	Ulcers
Bowel-colon	Fatigue	Menopause probs	Weight
Cancer	Gall Bladder		Winter Blues

Circle your Blood Type, if known: A B AB O

List any known allergies or sensitivities & what you do to manage the symptoms: