

Basic Client Information

Full Name: _____
First Name Full Middle Last Name

Date of Birth: ____/____/____ Main Phone: (____) ____-____ Secondary Phone: (____) ____-____
MM DD YYYY Home Mobile Work Home Mobile Work

Email Address: _____ Weight: _____ lbs

Address: _____ Height: ____' ____"

City: _____ State: ____ Zip: _____ Are you Pregnant? Y / N

Birth Parent Information (Optional - Used for a Specific Therapy, and will not be done in the first visit)

Mother's Full Name: _____
First Name Full Middle Maiden Name

Father's Full Name: _____
First Name Full Middle Last Name

Mother's Date of Birth: ____/____/____ Father's Date of Birth: ____/____/____
MM DD YYYY MM DD YYYY

I was: ____ Adopted ____ Foster Child ____ Parents were divorced/separated ____ Separated from parent(s) in other way

Emergency Contact Information

Emergency Contact: _____

Relationship: _____ Phone: (____) ____-____
Home Mobile Work

Medical Contact Information

Medical Doctor: _____ Phone: (____) ____-____ Do Not See One

Psychiatric Doctor: _____ Phone: (____) ____-____ Do Not See One

Other Doctor: _____ Phone: (____) ____-____ Do Not See One

Complementary Health Contact Information

Massage Therapist: _____ Phone: (____) ____-____ Do Not See One

Chiropractor: _____ Phone: (____) ____-____ Do Not See One

Herbalist: _____ Phone: (____) ____-____ Do Not See One

Other ACHP: _____ Phone: (____) ____-____ Do Not See One

Misc. Important Information

Do you have any metal in your body? Yes No If yes, where: _____

Allergies: _____

Main areas of Complaint / Issues

What brings you here, what are some of the main areas of complaint or issues?

Expectations

Please tell me what your expectations are through seeing me:

Life Story (First 25 years of life)

Tell me about your life,

How was your birth time (prenatal, pregnancy, actual labor)?

From birth until when you started school?

How was grade school?

How was middle school?

How was high school?

After high school to age 25?

Other things you have tried, or are trying

What are some other things that you are trying, or have tried in the past? Please explain what you have experienced with it, reactions, etc.

Medications or Herbal Supplements

Medication / Herb	Dosage	Reason for taking

Medical History

Condition	You	Father	Mother	Brother	Sister	Son	Daughter	Other
Abdominal Pain (specific / unknown)								
ADD/ADHD								
Alcoholism								
Allergies: _____								
Anemia								
Anesthesia Problems								
Anxiety Problems								
Arthritis: _____								
Asthma								
Bi-Polar Disorder								
Birth Defects								
Bleeding Problems								
Blood in stool								
Breast Lump / Discharge								
Breathing Difficulty								
Cancer: _____								
Change in Vision								
Chest Pain / Discomfort								
Chronic Back Issues								
Chronic Bronchitis								
Chronic Constipation								
Chronic Fatigue / Weakness								
Chronic Headaches								
Chronic Pain								
Chronic Tension								
Circulation Issues								
Concentration Issues / Concerns								
Coughing / Wheezing								
Depression								
Diabetes (Type 1 / Type 2)								
Diarrhea								
Discharge (penis or vagina)								
Easy Bruising / Bleeding								
Eczema								
Epilepsy								
Excessive Thirst / Urination								
Fevers / Chills / Sweats								
Fibromyalgia								
Genetic Diseases								
Glaucoma								
Hay fever								

Condition	You	Father	Mother	Brother	Sister	Son	Daughter	Other
Hearing problems								
Heart Attack								
High Blood Pressure (Hypertension)								
High Cholesterol								
HIV/AIDS								
Jaw Pain / Teeth Grinding								
Joint Pain								
Kidney Issues: _____								
Leaking Urine								
Leg Pain								
Liver Issues: _____								
Loss of Coordination								
Low Blood Pressure								
Lung Issues: _____								
Lupus								
Memory Loss								
Menopause Issues: _____								
Menstruation Issues: _____								
Mental Retardation / Disabilities								
Migraines								
Mitral Valve Prolapse								
Muscle Pain								
Nausea								
Nighttime Urination								
Numbness								
Osteoporosis								
Palpitations								
Prostate Issues								
Rash / Mole Change								
Ringing in Ears								
Sexual Function Problems: _____								
Skin Issues: _____								
Sleep Problems: _____								
Stress								
Stroke: _____								
Teeth / Gum Issues: _____								
Thyroid Disorders								
Tuberculosis								
Ulcers								
Unexplained Lumps								
Unexplained Weight Gain / Loss								
Unusual Vaginal Bleeding								
Vomiting								
Other: _____								
Other: _____								
Other: _____								

Other

Do you smoke? Yes No How many per day? _____ Do you drink alcohol? Yes No How much? _____

