CLIENT PROFILE

Date (01/01/2022): 02/01/22

Name, First, Middle, Last Name):

Age: DOB (01/01/1985): Male ☐ Female ☐

Address:

City: State:

Zip:

Home ☐ / Cell ☐ phone:

Occupation:

Email address:

Hight: Weight:

In Case of Emergency Notify: Relationship:

Address:

Phone #:

Family Physician: Phone:

Current Health Problems:

What are the most important health problems you would like to talk about today?

Health History: Check relevant areas and give brief details on the last page.

- ☐ Alcohol/Drug Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back/neck pain/injuries
- ☐ Bowel/Bladder problems
- ☐ Cancer
- ☐ Cardiovascular disorder
- ☐ Carpal Tunnel
- ☐ Chest discomfort
- ☐ Chronic or recurrent cough
- ☐ Cholesterol high/ low
- ☐ Diabetes
- ☐ Dizziness
- ☐ Pulmonary (lung) disorder
- ☐ **Pregnancy (current)**
- ☐ Respiratory problems
- ☐ Rheumatic fever
- ☐ Recurrent fatigue
- ☐ Stroke
- ☐ Disease of arteries
- ☐ Endocrine (gland) disorder
- ☐ **Epilepsy**
- ☐ **Electrical Hyper Reactivity**
- ☐ Foot/ankle problems
- ☐ Fractures
- ☐ Fibromyalgia
- ☐ Gout
- ☐ G.I. (digestive) disorder
- ☐ Heart Disease
- ☐ High Blood Pressur
- ☐ Herpes Genitals
- ☐ Hypoglycemia
- ☐ Hernia
- ☐ Hepatitis
- ☐ Swollen/stiff/painful joints
- ☐ Skin disorder
- ☐ Sciatica
- ☐ Sleeping problems
- ☐ Smoker
- ☐ Thyroid Disease
- ☐ Injury (serious)
- ☐ Immune/Blood disorder
- ☐ Knee/hip problems
- ☐ Lower Back Problems
- ☐ Liver Disease
- ☐ Lung disease
- ☐ Lymphedema
- ☐ Leg pain after walking short distances
- ☐ Musculoskeletal disorder
- ☐ Migraine or recurrent headaches
- ☐ Nervous System Disorders
- ☐ Nausea
- ☐ Overweight
- ☐ **Pacemaker**
- ☐ Psychological Problems
- ☐ Tuberculosis
- ☐ Urinary/Genital disorder
- ☐ Venereal Disease
- ☐ Vision/hearing problems
- ☐ Other_____

Hospitalizations: Dates and type of illness/injury/operation.

Medications and Supplements: Include prescription and nonprescription drugs, herbs, vitamins, minerals, etc.

Allergies: