INTEGRATIVE
HEALTH
MANAGEMENT
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Confidential Client Data Form

Name_____ Email_____

Address_____ Phone_____

City_____ State_____ ZIP _____ Fax_____

Primary health care provider _____ Phone _____

Occupation_____ DOB: _____

Referred by:_____ Sex: M F

Person to contact in an emergency:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS PROVIDING CLARIFICATION IN THE APPROPRIATE AREA.

_____ Do you smoke? _____ Do you drink alcoholic beverages?

_____ Are you pregnant? _____ Do you have high blood pressure?
Are you taking any medication for the high blood pressure?_____

_____ Do you have a history of serious physical injury?
Please specify:_____

_____ Do you have a history of psychological disorder?
Please specify:_____

List current medications, including aspirin, etc._____
_____

Prioritize the areas where you think we need to focus._____
_____

PREVIOUS HISTORY: (include year and treatment received)
Surgeries:_____
_____

Accidents:_____
_____

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Practitioner Notes & Client Comments:_____
_____
_____
_____
_____
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HEALTH HISTORY

MUSCULO-SKELETAL

___ bone or joint disease _____
___ tendonitis _____
___ bursitis _____
___ broken/fractured bones _____
___ arthritis _____
___ sprains/strains _____
___ low back, hip, leg pain _____
___ neck, shoulder, arm pain _____
___ headaches/head injuries _____
___ spasms/cramps _____
___ jaw pain/TMJ _____
___ lupus _____
___ other _____

CIRCULATORY

___ heart condition _____
___ varicose veins _____
___ blood clots _____
___ high blood pressure _____
___ low blood pressure_____
___ lymphedema _____
___ breathing difficulty _____
___ sinus problems _____
___ allergies _____
___ other _____

INFECTIOUS DISEASE

___ disease name(s) _____
_____

SKIN

___ allergies _____
___ rashes _____
___ athletes foot _____

___ other_____

DIGESTIVE

___ constipation_____
___ gas/bloating _____
___ irritable bowel syndrome _____
___ other _____

NERVOUS SYSTEM

___ herpes/shingles _____
___ numbness/tingling _____
___ chronic pain _____
___ fatigue_____
___ sleep disorders _____
___ other _____

REPRODUCTIVE

___ pregnant, stage _____
___ PMS _____
___ other _____

OTHER

___ cancer/tumors _____
___ diabetes _____
___ depression____ _____
___ drug/alcohol addiction _____
___ nicotine addiction _____

It is my choice to receive the healing and work and I am ready to take the next step. I understand that the modalities used are not meant to replace conventional medicine. I realize that the process is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. This also includes relief of phobias, addictions, or emotional trauma. I understand the practitioner does not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. If symptoms persist or become severe, a medical professional is to be consulted. I hereby release the person or persons providing these services from any liability of the services received. I certify that the facts given herein are correct and up-to-date and will notify the practitioner of any changes in my health status. **24 HOUR CANCELLATION POLICY!**

Signature: _____ Date: _____