Inside Wellness, LLC: Client Questionnaire and Medical History

Name_____ Date_____

Address _____

Email_____

Phone (days)_____(evening)_____ Age_____ Weight_____ Height_____

Married ☐ Separated ☐ Divorced ☐ Widowed☐ Single☐ Minor ☐ Partner☐

Occupation_____Employer_____

In case of an emergency, contact:_____ Phone_____

List your major challenges you'd like to overcome in order of importance to you:

1. _____

2. _____

3. _____

4. _____

What factors do you think may be contributing to your health challenges? (injury, diet, lifestyle, family history, relationships, stress, illness, job, finances, drug or alcohol use, etc. – rank in order)

1. _____

2. _____

3. _____

4. _____

Are you under the care of a physician and if so, what are you being treated for?

_____

Are you currently or have you in the past used the services of any of the following service providers (homeopath, acupuncturist, holistic health or nutritional consultant, chiropractor, massage therapist.) Please list_____

_____

Please list any medications you are taking and how long you have been taking them:

_____

_____

_____

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Please check conditions or symptoms you currently have or have had in the past:

Anemia ☐	Cancer ☐	Hepatitis ☐	Multiple Sclerosis ☐	Sinus Problems ☐
Anorexia ☐	Chemical Depend.☐	Hernia ☐	Osteoporosis ☐	Stroke ☐
Appendicitis ☐	Diabetes ☐	Herniated Disk ☐	Pacemaker ☐	Tendonitis ☐
Asthma ☐	Emphysema ☐	HIV/AIDS ☐	Parkinson's Disease ☐	Thyroid Problems ☐
Blood Clots ☐	Fibromyalgia ☐	High Blood Pressure ☐	Pinched Nerve ☐	TMJ ☐
Breathing Difficulties ☐	Fractures ☐	Jaw Pain/ TMJ ☐	Pneumonia ☐	Tuberculosis ☐
Bursitis ☐	Glaucoma ☐	Lymphedema ☐	Prosthesis ☐	Tumors, Growths ☐
Bronchitis ☐	Head Injuries ☐	Migraine Headaches ☐	Rheumatoid Arthritis ☐	Varicose Veins ☐
Bulimia ☐	Heart Disease ☐	Mononucleosis ☐	Rheumatic Fever ☐	Whiplash ☐

Other:

If true, finish this sentence: "I have never been well since…." _____

_____

Have you had any of the following: injuries, accidents, surgeries, shocks, traumas, abuses? If yes, please describe:_____

_____

_____

Do you have any allergies? If so, list them _____

_____

Lifestyle: How much (just pure)water do you drink per day?_____

Do you consume any of the following? If yes indicate how much:

	Yes	No	Amount
Alcohol	_____	_____	Drinks/Week_____
Coffee/Caffeine	_____	_____	Cups/Day_____
Cigarettes	_____	_____	Packs/Day_____
Recreational drugs	_____	_____	_____

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Exercise: None ☐ Daily ☐ Moderate ☐ Heavy☐

Work Activity: Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐

List any supplements (if any) you are presently taking. _____

_____

_____

_____

Do you have any food cravings?_____

Do you have any scars, piercings or tattoos on your body and if so, where? _____

_____

Pain: If you are currently in pain, when did the symptoms appear?_____

What treatments have you already received for your condition? Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care☐ None ☐ Other ☐

Type of Pain: Sharp☐ Dull☐ Throbbing☐ Numbness☐ Aching☐ Shooting☐ Burning☐ Tingling☐ Cramps☐ Stiffness☐ Swelling☐ Other☐_____

How often do you have this pain?_____ Is it constant or intermittent? _____ Does it interfere with your: Work☐ Sleep☐ Daily Routine☐ Recreation☐

Activities or movements that are painful to perform: Sitting☐ Standing☐ Walking☐ Bending☐ Lying Down☐ Working on a computer☐ Exercising☐ Other☐_____

Authorization: To the best of my ability, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions I may have made in completing this form.

I acknowledge that any information I receive in a session is educational in nature and is to be used at my own discretion.

_____ _____

Signature of Client, Parent, or Guardian Date