



Client History Form

Name:	Email:
Address:	City, State, Zip:
Home Phone:	Other Phone:
Cellular Phone:	Referred by:
Date:	Date of Birth:

Part 1. General Health

Describe the problem(s) for which you seek help.

Describe past medical history (previous injuries, accidents, surgeries, illnesses, etc.). Include approximate dates.

Have you ever been the victim of abuse or neglect?

Please list and describe any stresses in your life.

Please circle the level of stress.				
My family stress is:	None	Minimal	Moderate	Severe
My relationship stress is:	None	Minimal	Moderate	Severe
My work stress is:	None	Minimal	Moderate	Severe
My financial stress is:	None	Minimal	Moderate	Severe
My health stress is:	None	Minimal	Moderate	Severe
Other stress is:	None	Minimal	Moderate	Severe

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc.?

How many hours a night do you sleep? _____
 Is your sleep restful? _____
 If not, please explain: _____

Part 2. Family & Childhood

If additional space is needed, use back or attach an additional sheet.

In a few sentences, describe your relationship with your mother during your childhood (from your perspective).

In a few sentences, describe your relationship with your father during your childhood (from your perspective).

In a few sentences, describe what it was like to grow up in your family.

List any significant traumas from your past (premature birth, car accidents, divorce, abuse, mental illness, etc.):

Part 3.Recent Emotions

Please check any of the following feelings you have experienced in the last few months.			
<input type="checkbox"/> Abused	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Unable to grieve	<input type="checkbox"/> Panic
<input type="checkbox"/> Criticized	<input type="checkbox"/> Overwhelmed	<input type="checkbox"/> Apprehensive	<input type="checkbox"/> Intolerant
<input type="checkbox"/> Overworked	<input type="checkbox"/> Muddled	<input type="checkbox"/> Agitated	<input type="checkbox"/> Uncertainty
<input type="checkbox"/> Paralyzed	<input type="checkbox"/> Persecuted	<input type="checkbox"/> Uneasy	<input type="checkbox"/> Aggravated
<input type="checkbox"/> Depressed	<input type="checkbox"/> Guilty	<input type="checkbox"/> Distress	<input type="checkbox"/> Annoyed
<input type="checkbox"/> Rejected	<input type="checkbox"/> Easily irritated	<input type="checkbox"/> Fearful	<input type="checkbox"/> Angry
<input type="checkbox"/> Despair	<input type="checkbox"/> Anxious	<input type="checkbox"/> Impatient	<input type="checkbox"/> Outraged
<input type="checkbox"/> Helpless	<input type="checkbox"/> Sad	<input type="checkbox"/> Intimidated	<input type="checkbox"/> Nervous
<input type="checkbox"/> Hopeless	<input type="checkbox"/> Grieving	<input type="checkbox"/> Restless	<input type="checkbox"/> Worried

Part 3. Pain

Please list any areas of pain or discomfort in the body. Rate each area according to the scale below and list details, if necessary.

Rating:

- 1. Slightly aware of discomfort
- 2-3. Aware of discomfort as an aggravation
- 4-6. Pain is strong but you are still functional
- 7-9. Pain is so strong you are unable to function normally
- 10. You feel like you need to go to emergency room

Areas of pain and discomfort:

Date form completed: _____

Person completing form: _____