Client Information Sheet

Name: ______________________________ Sex: M / F Date of Birth: ___________
Address: ______________________________ City: ___________ Postal Code: ________
Phone: (H) __________ (W) __________ (C) __________ Email: ______________________
Employer: ______________________________ Occupation: ______________________
Family or Referring Physician: ______________________________ Phone :______________
Emergency Contact: ______________________________ Phone: ______________
How did you find me? ____
May I contact you post treatment for a follow-up? Y / N If yes, which phone #? H __ W __ C __

General Health History Information ~ Strictly confidential
Please check all that apply to you (past and present)

Cardiovascular
☐Angina
☐Diabetes
☐High blood pressure
☐Low blood pressure
☐Phlebitis
☐Poor circulation
☐Shortness of breath
☐TIA / Stroke
☐Vertigo

Musculoskeletal Pain
☐Arthritic pain
☐Carpal tunnel syndrome
☐Coccyx injuries
☐Fibromyalgia
☐Foot & ankle problems
☐Frozen shoulder
☐Gait disorders
☐Headaches/Migraines
☐Hernia
☐Knee & hip restrictions
☐Leg length discrepancies
☐Muscle pain tightness
☐Osteoarthritis
☐Osteoporosis
☐Pectoralis/breast pain
☐Pelvic problems
☐Plantar fasciitis
☐Postural problems
☐Repetitive strain injury
☐Sciatica
☐Scoliosis
☐Shin splints
☐Shoulder pain
☐Sporting injuries
☐Sprung ribs
☐Sternal pain
☐Tennis elbow
☐TMJ syndrome

Respiratory Concerns
☐Allergies
☐Asthma
☐Bronchitis
☐Chronic Cough
☐Emphysema
☐Hay Fever
☐Influenza
☐Sinusitis
☐Smoker
☐Sore throat/Tonsillitis
☐Wheezing

Women
☐Breast pain
☐Cramps/backache
☐Endometriosis
☐Excessive flow
☐Fibroids/cysts
☐Infertility
☐Irregular cycle
☐Menopause
☐Menstrual pain
☐Ovarian/Uterine problems
☐PMS
☐Pregnant (what trimester? __)

Genitourinary
☐Blood in urine
☐Frequent/painful urination
☐Hemorrhoids
☐Kidney infection/stones
☐Prostate trouble
☐Urinary/bladder infections

Digestive Disorders
☐Colic
☐Constipation/diarrhea
☐Crohn's Disease
☐Indigestion/heartburn
☐Irritable bowel syndrome
☐Nausea

General
☐Convulsions
☐Chills
☐Fever/sweats
☐Frequent colds
☐Headaches
☐Loss of sleep

Gastrointestinal
☐Acid Reflux
☐Constipation/diarrhea
☐Difficult digestion
☐Hernia
☐Kidney/bladder
☐Liver/gall bladder
☐Poor appetite
☐Ulcer

Infectious Disease
☐Chicken pox
☐Hepatitis A B C
☐HIV / AIDS
☐Other communicable disease
____

Other
☐Balance/dizziness
☐Bell's Palsy
☐Breast implants
☐Bunions
☐Bursitis
☐Chronic Fatigue
☐Dyslexia
☐Earache/ear infections
☐Electro medical devices
☐Fluid retention
☐Ganglion
☐Grinding teeth/crowding
☐Immune disorders
☐Jaw surgery
☐Meniere's Disease
☐Neuralgia
☐Orthotics
☐Tinnitus
☐Varicose veins

Any other medical conditions or health concerns? ____
____

Previous injuries and/or surgeries (please include bad falls, motor vehicle accidents, sports injuries)
____
____

Are you presently under a medical practitioners' care? Yes / No Why? ______________________________

Current medications (please include vitamins, herbs, and homeopathic medications)_____________________
____

Do you regard your health problem(s) to be ☐ severe ☐ moderate ☐ light

Are you currently receiving treatment from any of the following? Why?_________________________________

☐ Massage therapist ☐ Physiotherapist ☐ Acupuncturist
☐ Chiropractor ☐ Energy worker ☐ Other___________________
____

How successful were they? ☐ very successful ☐ partly successful ☐ not successful

In what way do you expect your health problem(s) to improve following consultations at this centre?___________
____

Over what period of time do you expect total recovery to occur?____

Please circle the areas where you are experiencing any pain & circle the pain description.

PAIN DESCRIPTION:

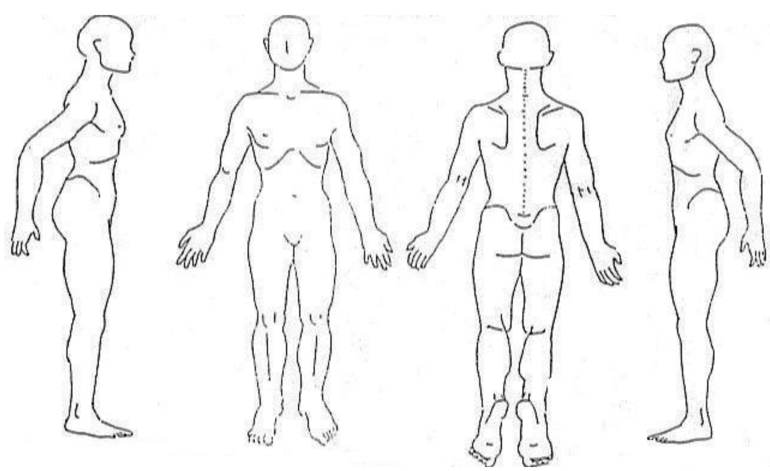
Onset: Sudden, gradual

Duration: Hours, days, weeks, months

Frequency: Seldom, intermittent, frequent, constant

Type: Sharp, dull, achy, tingly

Severity: Mild, moderate, severe



What is your daily water intake? (not including fruit juice, soft drinks, tea, coffee, alcohol)
☐ 3 Litres ☐ 2 Litres ☐ 1 Litre ☐ 500 ml ☐ less

Briefly describe your diet?____
____
_

What are your favorite foods?
____

Are your bowel movements ☐ daily ☐ less than daily

How often do you exercise? ☐ daily ☐ weekly ☐ occasionally ☐ never

On a scale of 1-10 what is your daily energy level? ____

On a scale of 1-10 where do you want your daily energy level to be? ________________________________

Do you smoke cigarettes? If yes, how many per day? ____

Do you exercise regularly? If yes, briefly describe ____

Please tick any of the following issues which relate to you and place *2 ticks* against those you would like to resolve or improve.

Alcohol use	Enemies	Marriage	Sexual problems
Ambition	Exhaustion	Memory	Shyness
Anger	Fears	Motivation	Sleep
Anxiety	Finances	Nervousness	Social skills
Career choices	Friends	Nightmares	Stress
Children	Grieving	Pain	Suicidal thoughts
Concentration	Headaches	Parenting	Temper
Depression	Insomnia	PMS	Thoughts
Dizziness	Inferiority	Relaxation	Tiredness
Divorce	Legal Matters	Regrets	Unhappiness
Drug use	Loneliness	Self control	Unpleasant memories
Education	Making decisions	Separation	Work

Is there anything else in your life that you would like to:
☐ stop doing ☐ start doing ☐ do better ☐ do differently

Please briefly explain:____
____
____
____

Consent to treatment

I UNDERSTAND that my practitioner is not a licensed MEDICAL health care provider.

I ACKNOWLEDGE that any of the therapies received from Sharon Walsh are not a substitute for medical care, medical examination or diagnosis and the results are not guaranteed.

I VERIFY that all information accurately reflects my past and current medical conditions.

I DECLARE that I have received a complete explanation of the treatment/services that I may receive from Sharon Walsh and hereby authorize and consent to treatment.

I UNDERSTAND that the client therapist relationship will be held in strict confidence.

I AGREE to pay my full account at each visit or treatment, including fees for services, cost of supplements and remedies, administrative fees, as well as other applicable fees. Appointment cancellation requires 24 hours notice otherwise full charges apply for missed appointments.

____ ____________________

Client Signature (Parent/Guardian if under 18 years of age) Date

____

Print name

____

Witness