

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:

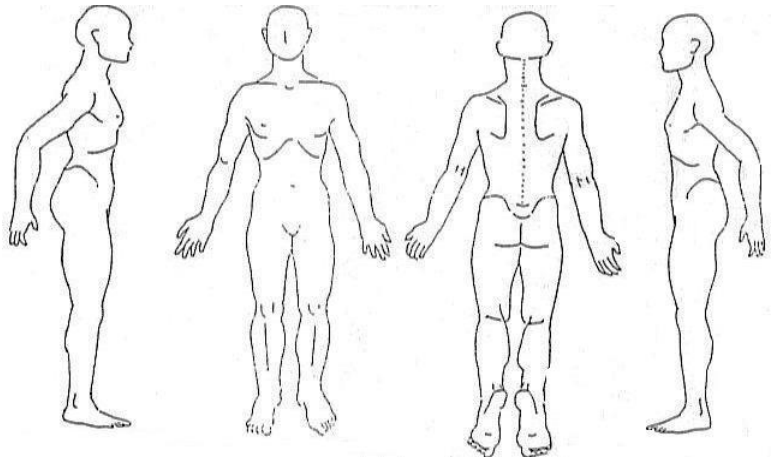
Onset: Sudden, gradual

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 Andy Aruvald 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 Andy Aruvald 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