Family Life Matters, LLC

Holistic Care for the Whole Person

CLIENT HISTORY FORM

Your Name: Date of Birth:

Date you are filling out this form:

Did someone refer you here? No____ Yes_____ Who?_____

How can we help you today?

TELL US ABOUT YOURSELF:
Home situation (circle, or add in writing):

Single_____ Married (how long_____) Divorced (how long_____) Widowed (how long_____)

Domestic partnership_____ Children?_____ Are they healthy?_____

Person to call in an emergency: _____ Phone #:_____

Employment:
Status: full-time_____ part-time_____ retired_____ disabled_____ homemaker_____

Occupation/type of work/jobs:_____

Habits: Do you smoke? No_____ Yes_____ If yes, how many packs per day?_____
If you have quit, how long ago?_____

Do you use alcohol? No_____ Yes_____ If yes, how often do you drink?_____
If you have quit, how long ago?_____
Do family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____
If Yes, explain_____

PAST MEDICAL HISTORY:
Please list any diseases from which you <u>currently</u> suffer (heart, lung, TB, kidney, psychiatric problems, etc.):

Please list other medical conditions from which you have suffered in the past:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction

FAMILY HISTORY:
Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Colon or rectal cancer								
Other cancer								
Heart disease								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

Client History Form

Circle any items that apply to you:

SYMPTOM REVIEW

Gastrointestinal

- poor appetite
- abdominal pain
- indigestion
- heartburn
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding or blood in stools
- history of liver disease or abnormal liver tests

Cardiovascular

- chest pain
- history of angina or heart attack
- history of high blood pressure
- history of irregular beat
- history of poor circulation

Pulmonary/lungs

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing

Muscle/joint/bone

- swelling of ankles or legs

pain, weakness or numbness in:

- arms or hands
- back or hips
- legs or feet
- neck or shoulders

Neurologic/Psychiatric

- history of stroke
- blackouts or loss of consciousness
- depression
- anxiety
- psychosis
- inattention
- memory loss
- angry outbursts

General

- weight gain/loss of 10+ lbs during last 6 months
- trouble falling asleep
- trouble staying asleep
- fever
- headache
- overeating

Eyes, ears, nose, throat

- blurred vision
- other change in vision
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus problems
- hoarseness

Genitourinary

- frequent or painful urination
- blood in urine
- kidney stones

Skin

- itching
- easy bruising
- change in moles

Endocrine

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst

Women only

- abnormal Pap smear
- Date of Last Menstrual period_____
- sexually active? Yes No
- problems with sexual intercourse
- bleeding between periods

date of last mammogram_____

Men only

- PSA done last_____
- trouble urinating
- sexually active? Yes No
- erectile dysfunction

Comments that are important to know on any items that you circled:

Anything else?

- Are you experiencing any unusually stressful situations?

- Are there any specific personal issues you would like to bring up at the time of your visit?

Immunizations: if YES, give approximate year given

Pneumococcal	No_____	Yes_____
Hepatitis A	No_____	Yes_____
Hepatitis B	No_____	Yes_____
Tetanus	No_____	Yes_____

Do you use seatbelts? No_____ Yes_____

Guns kept in home? No_____ Yes_____

Transfusions: Have you ever received a blood transfusion? No_____ Yes_____ When?_____

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT

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