Client History and Information

Thank you for choosing TRU Integrative Health and Wellness, LLC. Please answer the questions below as honestly and completely as possible so that we might know how to best support you on your journey toward health and wellness.

Client Name:______________________________ DOB: ____/____/____ Age: _______

❑ Male ❑ Female Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Separated

Address: ____

Primary Telephone Contact:____________________ Can we leave a message? ❑ Yes ❑ No

Email Address: _________________________ Can we contact you by email? ❑ Yes ❑ No

Can we send you a text message regarding scheduling issues? ❑ Yes ❑ No

Local Emergency Contact: ________________ Telephone: ___________ Relation: ________

How did you hear about us? Please be as specific as possible. ___________________________

❑ Check here to opt out of receiving notification via email of upcoming events, workshops, and discounts.

Physical Health

If you are seeking support for mental, emotional, or relational concerns, this section is optional.

Primary physical complaints: ____

____

Height: ___ ft. ___ in Current Weight: _____ lb Lowest Adult Weight: _____ lb

Ideal Weight: ______ lb Are you presently gaining or losing weight? ______________

Would you like help losing or gaining weight? ❑ Yes ❑ No

Are you currently under the care of any other physician or health care professional? ❑ Yes ❑ No

If yes, Doctor's name: ___________________________ Specialty:________________________

Reason for care: ____________________________ Date of last visit:___________________

Other current treating doctors: ____

____

Health History:

Illness or Injury Approx. Date Complications/Comments Full Recovery? ❑ Yes ❑ No

____

____

____

Surgery Approx. Date Complications/Comments Full Recovery? ❑ Yes ❑ No

____

____

____

Family History: Cancer__ Diabetes__ Heart Problems__ Mental Illness__ Other ________

Please explain: ____

____

Antibiotic runs past year: ______ Avg. # runs past 5 years: ______

Long-term exposure to chemicals, pesticides, herbicides, radiation, solvents, or heavy metals?

Y / N If yes, please explain:____

Do you have/ have you ever had metal fillings in your teeth? Y / N Any tooth extractions? Y / N

Do you currently have any trouble with your teeth? Y / N Please explain:_________________

What time(s) of the day are you most tired? ___________________________________

Bowel movements: >1/day____ 1/day____ Every 2 days____ 3/week____ 2/week____Other_____

Current Medications/Supplements:

Please include prescription drugs as well as over the counter medications and supplements.

Medication/Supplement	Dosage	Purpose	Side Effects

Menstrual History:

Date of last menstrual cycle:____________ Are your cycles regular? ❑ Yes ❑ No

If no, please explain:____

Menstrual Cramping: ❑ Yes ❑ No If yes: Slight ____ Moderate ____ Severe ____

Other PMS symptoms: ❑ Yes ❑ No Please indicate: Bloating ____ Cravings ____

Back Pain ____ Moodiness ____ Other____

Are you currently pregnant? Y / N Weeks: ____ Complications: _______________________

If pregnant, are you interested in information about natural pregnancy and/or childbirth? Y / N

Birth Control Information:

Have you ever used hormonal-type birth control (ie: patch, pill, injection, implant, IUD)? Y / N

Are you currently on hormonal-type birth control? Y / N Total years taken?:________

Reason for starting? PMS ____ Irregular cycle ____ Birth Control ____ Other ____________

Appetite and Eating:

How would you describe your appetite? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have your eating habits changed within the past few days/weeks/months: ❑ Yes ❑ No

If yes, please list changes ____

____

Do you struggle with restrictive or binge eating? ____________________________________

Are you currently or have you ever received treatment for an eating disorder? ____________

Are you following any diets/food plans?

Diabetes ❑ Yes ❑ No Low fat/Low Cholesterol ❑ Yes ❑ No
Weight Loss ❑ Yes ❑ No Low Sodium/No Salt ❑ Yes ❑ No
Other:____

Are you a vegetarian or vegan? ❑ Yes ❑ No
If yes, do you eat any of the following?

Eggs	❑ Yes	❑ No	Cheese	❑ Yes	❑ No
Yogurt	❑ Yes	❑ No	Milk	❑ Yes	❑ No
Poultry	❑ Yes	❑ No	Fish	❑ Yes	❑ No

Please list any known food allergies or sensitivities:_________________________________
____
Are there foods you dislike?____
What are your favorite foods or snacks?____
Do you avoid eating any foods because of cultural or religious practices? ❑ Yes ❑ No
If yes, please specify:____

Have you ever or do you currently smoke? ❑ Yes ❑ No If quit, how long ago? _________
Quantity: ❑ Less than 10/day ❑ 10-20/day ❑ More than 20/day

How often do/did you drink alcoholic beverages? ❑ Daily ❑ Weekly ❑ Monthly ❑ Never
Is your drinking problematic for you? ❑ Yes ❑ No Are you currently in recovery? ❑ Yes ❑ No

Do you currently use any other drugs? (please specify) ______________________________
Do you have a history of using drugs? ❑ Yes ❑ No Are you currently in recovery? ❑ Yes ❑ No

Are you able to do physical activity? ❑ Yes ❑ No If so, how often are you active? ________
Please list types of exercises/activities you enjoy________________________________

Symptom Profile: PLEASE FILL OUT COMPLETELY

Please circle the symptoms that are relevant to you and list approximate date of start and frequency of experience in space given.

Suicidality: Y/N If so, please indicate: Thoughts: **Y/N** Plan: **Y/N** Intent: **Y/N** Hist. of attempts: **Y/N**

Immediate need for food, shelter, safety, or medical care (please describe): ____________
____

Loss of Interest ______________________ Hopelessness ____________________________
Grief/Loss _________________________ Depressed Mood __________________________
Fatigue/Low Energy __________________ Difficulty Concentrating ______________________
Recent increased or decreased need for sleep ____
Recent change in appetite (please describe) ____
Desire/Acts of self-harm (please describe) ____
Mood Swings _______________________ Expansive/Elevated Mood ___________________
Risky Behavior ______________________ Irritability ______________________________
Anger ____________________________ Impulsiveness ____________________________
Thoughts/Desire to harm others: ____
Anxiety/Worry ______________________ Racing Thoughts __________________________
Neck stiffness/pain ___________________ Back stiffness/pain __________________________
Pain elsewhere in the body (please describe) ____
Difficulty falling asleep________________ Difficulty staying asleep ______________________
Tired upon awakening _________________ Nightmares ______________________________
Digestive difficulties (please describe)____
Allergies/Sinus Problems _______________ Headaches _______________________________
Memory Challenges ___________________ Spacing out/Blacking out ____________________
Loss of Time _________________________ Dissociation _____________________________
Flashbacks __________________________ Startle Easily ____________________________
Emotionally Numb ____________________ Panic ___________________________________
Substance Abuse ______________________ Challenges with Food/Eating __________________
Weight Related Issues __________________ Sexual Issues ____________________________
Hearing things others don't ______________ Seeing things others don't ____________________
Relationship Difficulties (please describe) ____
Other (please list): ____
____
____
____

Mental/Emotional/Relationship Health

If you are seeking support around solely physical concerns, this section is optional.

Please describe your presenting concerns in as much detail as possible: _______________

____

____

____

____

____

What are your goals for therapy? ____

____

____

Have you been in therapy before? (Please list) __________________________________

____

____

Have you ever been in an inpatient or residential psychiatric facility? (Please list and describe):

____

____

Current Psychiatric Medications:____

____

Past Psychiatric Medications: ____

____

Prior Mental Health Diagnoses:____

____

Which of the above has been helpful for you and why?_____________________________

____

What has not been helpful and why not? ____

____

Based on your past experiences, are there things that you know you specifically want or don't want from your therapist at TRU? ____

____

____

Client History:

Please briefly describe the family you grew up in (members, dynamics, experiences, etc.):

____

____

____

____

Please briefly describe your current family: ________________________________

____

____

____

Other significant relationship history: ____

____

____

Who provides you with emotional support?________________________________

Educational level/history: ____

Occupational history: ____

Leisure interests: ____

Spiritual, religious, and cultural practices: _______________________________

____

Personal strengths: ____

Personal challenges or weakness: ______________________________________

Are you now experiencing, or have you ever experienced, any of the following events? If yes, please list age of occurrence, by whom, and whether the event occurred once or more.

❑ Yes ❑ No Physical assault or abuse:________________________________

____

❑ Yes ❑ No Sexual assault or abuse:________________________________

____

❑ Yes ❑ No Emotional or verbal abuse:______________________________

____

❑ Yes ❑ No Parental neglect: ____________________________________

____

❑ Yes ❑ No Domestic violence: ___________________________________

____

❑ Yes ❑ No Violent crime: ____
____

❑ Yes ❑ No Participating in or witnessing combat:__________________________
____

❑ Yes ❑ No Ritual abuse or torture:_____________________________________
____

❑ Yes ❑ No Other Traumas (please list) :________________________________
____

Please thoroughly describe how you believe these experiences have impacted or affected you:
____
____
____
____
____

What else do you want to be sure that we know about you? ______________________________
____
____
____

Thank you for filling this document out thoroughly! Your time and attention will truly help us to help you to the best of our ability!

*I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge***.**

____

Client Signature Date