TRU

Integrative Health & Wellness

Client History and Information

Thank you for choosing TRU Integrative Health and Wellness. 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's Name:_____ DOB: ____/____/____ Age: _____

If Minor, Parent/Legal Guardian Name: _____

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

Address: _____

Primary Telephone Contact:_____ Other:_____

Can we leave a message: ❑ Yes ❑ No

Email Address: _____

Emergency Contact: _____ Telephone: _____

Occupation/Employment: _____

How did you hear about us? _____

Physical

Height: __ ft. __ in Current Weight: _____ lb Lowest Adult Weight: _____ lb
Ideal Weight: _____ lb Are you presently gaining or losing weight? _____

Are you currently under the care of a physician or other health care professional? Y / N

If yes, Doctor's name: _____ Specialty:_____

Issues Addressed: _____ Date of last visit:_____

Doctor's name: _____ Specialty:_____

Issues Addressed: _____ Date of last visit:_____

Doctor's name: _____ Specialty:_____

Issues Addressed: _____ Date of last visit:_____

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List any major illnesses or injuries with approximate dates:

Illness or Injury Approx. Date Complications or Comments Full Recovery? Y/N

_____
_____
_____
_____
_____

List any surgery or operations with approximate dates:

Surgery Approx. Date Complications or Comments Full Recovery? Y/N

_____
_____
_____
_____
_____

Other previous medical hospitalizations:_____

_____
_____
_____

Please explain any significant medical problems, symptoms, or illnesses: _____

_____
_____
_____
_____
_____

Family Health History

Any family history of serious illness? Cancer_____ Diabetes_____ Heart Problems_____ Other_____

_____
_____

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Current Medications/Supplements:

Please include over the counter medications and supplements

Medication/Supplement	Dosage	Purpose	Side Effects

ANTIBIOTICS: # Antibiotic runs past year: _____ Avg. # runs past 5 years: _____

To the best of your knowledge, have you ever had 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_____

Menstrual History:

Date of last menstrual cycle:_____

Are your cycles regular? Y / N If no, please explain:_____

Menstrual Cramping: Y / N If yes: Slight_____ Moderate_____ Severe_____

PMS symptoms: Y / N

If so, what? Bloating ____ Cravings ____ Back Pain ____ Moodiness ____ Other_____

Are you pregnant? Y / N

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Birth Control Information:

Have you ever used hormonal-type birth control (i.e.: 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 _____

COMMON COMPLAINTS SURVEY: PLEASE FILL OUT COMPLETELY

Please circle those that apply in your case. If you circle one, please include details of the problem on the blank line.

Headaches _____

Fatigue / Low Energy _____

Neck stiffness or pain _____

Back stiffness or pain _____

Pain anywhere in the body_____

Trouble getting to sleep_____

Tired upon awakening in the morning _____

Waking in night and having trouble getting back to sleep_____

Irritability/ mood swings_____

Depression / Anxiety _____

Digestive gas_____

Bloating_____

Heartburn / Reflux _____

Diarrhea / Constipation _____

Allergies / Sinus Problems _____

Please list your main health complaints in order of importance to you:

1. Description of your **MAIN or WORST** health concern:_____
_____

Onset:_____ How often does it bother you?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have you tried?_____

Has this problem been getting better, worse or staying the same? _____

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2. Description of your **SECOND WORST** health concern:_____
_____

Onset:_____ How often does it bother you?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have you tried?_____

Has this problem been getting better, worse or staying the same? _____

3. Description of your **THIRD WORST** health concern:_____
_____

Onset:_____ How often does it bother you?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have you tried?_____

Has this problem been getting better, worse or staying the same? _____

4. Description of your **FOURTH WORST** health concern:_____
_____

Onset:_____ How often does it bother you?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have you tried?_____

Has this problem been getting better, worse or staying the same? _____

5. Description of your **FIFTH WORST** health concern:_____
_____

Onset:_____ How often does it bother you?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have you tried?_____

Has this problem been getting better, worse or staying the same? _____

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Nutrition/Diet/Fitness

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 _____
_____
_____

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	❑ Yes	❑ No			

If weight loss or other, please describe: _____
_____
_____

Have you experienced any of these symptoms during the past few days/weeks/months?

Nausea	❑ Yes	❑ No	Heartburn	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No	Abdominal Pains	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No	Bloating/Cramps	❑ Yes	❑ No
Constipation	❑ Yes	❑ No	Other Illness	❑ Yes	❑ No

Are you experiencing any symptoms now? ❑ Yes ❑ No
If yes, please explain: _____

Are you a vegetarian? ❑ 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 food allergies or food sensitivities:_____
_____
_____
Are there foods you dislike?_____
_____
_____
If so, why? _____
_____
What are your favorite foods or snacks?_____
_____
_____
Who does the cooking at home? _____ Who does the food shopping? _____
How often during the week do you eat out?_____

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How often do you bring your own meals or leftovers to work? _____
Do you avoid eating any foods because of cultural or religious practices? ❑ Yes ❑ No
If yes, please specify:_____
_____

Please circle if you have ever had any of the following illnesses or complications:

Hypertension	Osteoporosis	Cancer
High Cholesterol	Arthritis	Migraines
Over Weight/Obese	Back or Joint Pains	IBS/IBD/Chron's Disease
High Triglycerides	Sleep Apnea	Hypothyroidism
Asthma	Other: _____	

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

How often do/did you drink any of the following: beer, wine, wine coolers, hard liquor, mixed drinks, malt liquor (Leave blank if you don't)?
❑ Daily ❑ Weekly ❑ Monthly ❑ Never

Are you able to do physical activity? ❑ Yes ❑ No
If you can, how often are you active?_____
Please list types of exercises/activities you enjoy?_____
_____
What prevents you from doing regular physical activity? _____
_____
Please rate your level of confidence in changing your eating patterns (scale 1-10): _____
Please rate your level of confidence in changing your physical activity level (scale 1-10): _____
Please rate your level of confidence in maintaining weight loss (scale 1-10):_____

Rate your eating patterns based on what you believe contributes most to weight gain:

_____ Eating and/or snacking constantly throughout the day
_____ Choosing unhealthy foods (ie: Fast Food, Candy, Fried Food)
_____ Eating or snacking late
_____ Long gaps between meals – 5 or more hours between meals
_____ Skipping meals
_____ Eating in response to stress or emotions (positive or negative)
_____ Eating at social or business functions (i.e. celebrations, gatherings, holidays, etc.)
_____ Eating large portions
_____ Eating too fast

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Please write your diet recall from the previous day in the space provided below:
(Note: Skip this section if you will be submitting a copy of the Food and Activity Diary).

Date	Time	Type of Food – Details	Amount	Where

*(*Continue on below if necessary)*

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Mental/Emotional

Reason for seeking psychotherapy/counseling: _____
_____
_____
_____
_____

What would you like to see different about yourself or your life as a result of being in therapy?
_____
_____
_____
_____

Previous psychiatric hospitalizations or inpatient treatment (Please list reason and dates):
_____
_____
_____
_____

Previous outpatient treatment (Please include names of providers, dates of care, and locations):
_____
_____
_____
_____

Past Psychiatric Medications: _____
_____
_____

Current 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? _____
_____
_____

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Current Symptoms: (Check all that apply)

___ Long periods of sadness
___ Loss of interest
___ Fatigue
___ Change in sleeping or eating
___ Nightmares
___ Loss of time
___ Feeling disconnected from body
___ Difficulty feeling emotions
___ Difficulty concentrating
___ Intrusive memories
___ Racing thoughts
___ Physical pain
___ Memory challenges
___ Thoughts of suicide
___ Self-harm behavior
___ Substance Abuse
___ Panic Attacks
___ Relationship difficulties
___ Mood swings
___ Startle easily
___ Hearing voices
___ Spacing out/blacking out
___ Anger
___ Seeing things others don't
___ Feeling disconnected from self, others, or body
___ Other symptoms: _____
_____
_____

Please briefly describe the family you grew up in:_____
_____
_____
_____

Please briefly describe your current family: _____
_____
_____
_____

Who provides you with emotional support?_____
_____
_____
_____

Please describe your leisure, educational, and professional pursuits:_____
_____
_____
_____

Are you now experiencing, or have you ever experienced, any of the following events? If yes, please list when and by whom.

❑ Yes ❑ No Physical assault or abuse:_____
_____

❑ Yes ❑ No Sexual assault or abuse:_____
_____

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❑ 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) :_____
_____

How do you believe these experiences have affected you?_____
_____
_____
_____
_____

Reiki/Massage

Have you ever had a Reiki session before? ❑ Yes ❑ No
If yes, when was your last session? _____ Number of previous sessions _____

Have you ever had a massage before? ❑ Yes ❑ No
If yes, when was your last massage? _____ Number of previous massages _____

Do you have a particular area of concern? _____
_____
_____

Are you sensitive to perfumes or fragrances? ❑ Yes ❑ No
If Yes, please explain:_____

Are you sensitive to touch or have difficulty with touch for physical or emotional reasons?
❑ Yes ❑ No If yes, please explain:_____

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Reason for Session: _____ Relaxation and Stress Reduction _____ Specific Issue

Please explain:_____
_____
_____
_____

Is there anything else you feel like we need to know in order to be most helpful to you?
_____
_____
_____
_____

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

_____

Client Signature Date

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