

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: _____

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_____

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

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? _____

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? _____

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? _____

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

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)

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? _____

Current Symptoms: (Check all that apply)

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

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: _____

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