## CLIENT HISTORY

**The following information will be held completely confidential. Please answer to the best of your ability.**

Name ______________________________ SSI#______ - _____ - ________

Street ________________________________________________

City ____________________ State __________ Zip __________

Home Phone____________________ Work ____________________

Age ____ Height________ Weight __________ Sex ______ Birthdate__________

Occupation ____________________________________________

Physician _____________________________________________

### CURRENT HEALTH INFORMATION

Major Physical Complaint or Problem if any: ____________________

________________________________________________________

When did you first start experiencing pain? ____________________

What do you believe is physically wrong with you? ________________

________________________________________________________

Have you ever had a similar problem before? __Yes __No *If Yes, when & what did you do for it:*

________________________________________________________

What activities or positions aggravate it? ______________________

What activities or positions relieve it? ________________________

Is the condition getting progressively worse? ____Yes ___ No Constant ___ Comes & goes _____

Is the condition interfering with your ( ) work ( ) sleep ( ) daily routine ( ) all

Has there been a medical diagnosis? ____Yes __ No If yes, when? __________

Doctor's Name ____________________ Treatment ____________

________________________________________________________

Did it help? ____________________________________________

Adaptive Attitudes In Fitness, Inc.
1480 Hickory Rd.
Canton, Ga. 30115

## PAST MEDICAL HISTORY

Please list any surgeries you have had, including the approximate dates, and any remarks that you may have about your recuperation from the surgery: ______________________

______________________________________________________________

Any broken bones in your life? (what & when) ______________________

______________________________________________________________

Have you ever been involved in an automobile accident? Yes_____ No___ If yes, please list when and injuries incurred: ______________________

______________________________________________________________

______________________________________________________________

List any other serious accidents or falls you can remember and what treatment, if any you received: ______________________

______________________________________________________________

______________________________________________________________

Have you ever received chiropractic care? _____Yes ___No

For what condition: ______________________ Did it help? ___Yes ___No

Check any of the following which you currently have or have been diagnosed with in the past:

| | | | | |
|---|---|---|---|---|
| ( ) Aids | ( ) Asthma | ( ) Appendicitis | ( ) Diphtheria | ( ) Scarlet fever |
| ( ) Polio | ( ) Malaria | ( ) Tuberculosis | ( ) Anemia | ( ) Whooping Cough |
| ( ) Measles | ( ) Mumps | ( ) Small Pox | ( ) Chicken Pox | ( ) Diabetes |
| ( ) Cancer | ( ) Heart Disease | ( ) Goiter | ( ) Influenza | ( ) Pleurisy |
| ( ) Alcoholism | ( ) Venereal Infection | ( ) Arthritis | ( ) Epilepsy | ( ) Mental Disorder |
| ( ) Lumbago | ( ) Eczema | ( ) Hypo-Thyroid | ( ) Hyper-Thyroid | |
| ( ) Others: | | | | |

***SKIN & HAIR:*** Check any of the following which applies to you:

| | | | | |
|---|---|---|---|---|
| ( ) Rashes | ( ) Ulcerations | ( ) Hives | ( ) Itching | ( ) Eczema |
| ( ) Pimples | ( ) Dandruff | ( ) Loss of Hair | ( ) Change in Hair | ( ) Purpura |
| ( ) Change in Skin | ( ) Other Skin Problems: | | ( ) Other Hair Problems: | |

**HABITS:** Check any of the following which applies to you:

( ) Cigarettes. How many a day ____________
( ) Coffee. How many cups ____________
( ) Tea. How much ____________
( ) Cola. How much ____________
( ) Alcohol. How often ____________
( ) Drugs. What kind ____________
( ) Sugar. Intake light___ med___ heavy___
( ) Salt Intake light___ med___ heavy___

**HEAD, EYES, EARS, NOSE & THROAT:** Check any of the following which applies to you:

( ) Dizziness ( ) Concussions ( ) Migraines ( ) Glasses ( ) Eye Strain
( ) Eye Pain ( ) Poor Vision ( ) Ear Aches ( ) Night Blindness ( ) Cataracts
( ) Blurry Vision ( ) Nose Bleeds ( ) Color Blindness ( ) Ringing in Ears ( ) Poor Hearing
( ) Mucus ( ) Sinus Problems ( ) Dry Throat ( ) Dry Mouth ( ) Jaw Clicks
( ) Copious Saliva ( ) Teeth Problems ( ) Grinding Teeth ( ) Facial Pain ( ) Gum Problems
( ) Spots in eyes ( ) Sores on lips ( ) headaches where & when: ____________
( ) Other head or neck problems: ____________ ____________ ____________ ____________

**GENERAL:** Check any of the following which applies to you:

( ) Poor Appetite ( ) Heavy appetite ( ) Poor sleep ( ) Heavy sleep ( ) Insomnia
( ) Fatigue ( ) Tremors ( ) Vertigo ( ) Cold hands ( ) Cold feet
( ) Cold back ( ) Cold abdomen ( ) Fevers ( ) Chills ( ) Night sweats
( ) Sweat easily ( ) Cravings ( ) Localized weakness ( ) Poor circulation ( ) Change in appetite
( ) Sudden energy drop at what time ____________ a.m. ____________ p.m.
( ) Peculiar tastes: ____________
( ) Peculiar smells: ____________
( ) Strong thirst for: hot drinks _____ cold drinks _____
( ) Bleed or bruise easily Where: ____________ ____________

**CARDIOVASCULAR:** Check any of the following which applies to you:

( ) High blood pressure ( ) Low blood pressure ( ) Chest pain
( ) Fainting ( ) Irregular heartbeat ( ) Dizziness
( ) Cold hands/feet ( ) Swelling in hands/feet ( ) Blood Clots
( ) Phlebitis ( ) Difficulty breathing ( ) Other: ____________

Blood Pressure reading if available: Date BP taken: ____________ Reading: ____________

**RESPIRATORY:** Check any of the following which applies to you:

( ) Cough ( ) Coughing blood ( ) Asthma

( ) Bronchitis ( ) Pneumonia ( )Difficulty in breathing when lying down

( ) Tight Chest ( ) Production of phlegm -*what color* ________ ( ) Other: ________

**GASTROINTESTINAL:** Check any of the following which applies to you:

( ) Nausea ( ) Vomiting ( ) Diarrhea

( ) Gas ( ) Belching ( ) Black stools

( ) Bad breath ( ) Rectal pain ( ) Hemorrhoids

( ) Constipation ( ) Bloody stools ( ) Sensitive abdomen

( ) Pain or cramps ( ) Gall bladder problems

( ) Liver trouble ( ) Gas/bloating after meals

( ) Heartburn ( ) Weight trouble: Excessive ______ Low weight ______

*Bowel Movements:*

Frequency: ________

Color: ________

Odor: ________

Texture: ________

Form: ________

( ) Laxative use: ____per week____

**GENITO-URINARY:** Check any of the following which applies to you:

( ) Pain on urination ( ) Frequent urination ( ) Blood in urine

( ) Urgency to urinate ( ) Unable to hold urine ( ) Kidney stones

( ) Venereal disease ( ) Impotency

( ) Wake up to urinate: How often: _____ # times a night time: ________

( ) Other G/U problems: ________

**PREGNANCY AND GYNECOLOGY:**

Number of pregnancies: ______ Number of births ________ Premature births ________

Age at first menses ________ Period (days) _ Irregular periods: Yes _____ No ________

Menstrual Flow: (describe) ________

Clots ________ Yes ________ No Last Menses ________ Last Pap Smear ________

( ) Vaginal discharge ( ) Vaginal sores ( ) Breast lumps ( ) Menopause

Birth control (type and duration) ________

Changes in body/psyche prior to menstruation:

( ) Pre-menstrual syndrome ( ) Menstrual cramping ( ) Lack of energy

( ) Diminished sex drive ( ) Excessive perspiration ( ) Genital herpes

Are you currently pregnant? No____ Yes ______ How many months ________

Other gynecological facts: ________

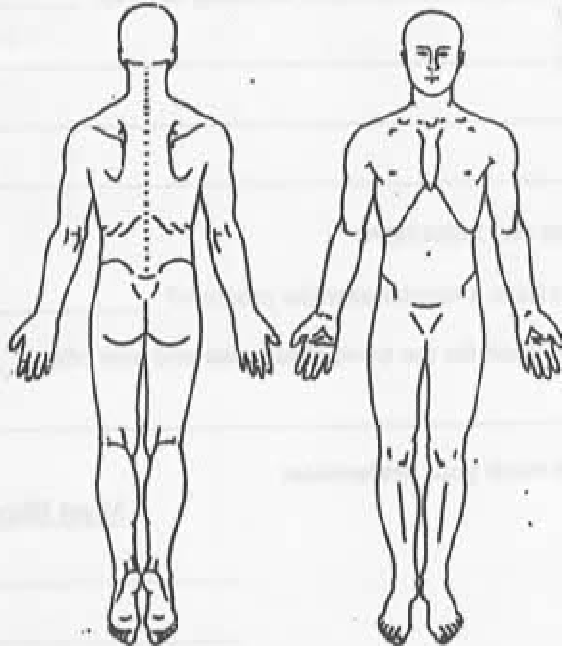
**NEUROPSYCHOLOGIAL:** Check any of the following which applies to you:

( ) Numbness ( ) Paralysis ( ) Dizziness ( ) Forgetfulness ( ) Confusion
( ) Seizures ( ) Anxiety ( ) Bad temper ( ) Easily stressed ( ) Concussion
( ) Depression ( ) Convulsions ( ) Irritability ( ) Twitching ( ) Ringing in ears
( ) Loss of sleep ( ) Inner-nervousness ( ) Cold/tingling Extremities ( ) Headaches: (*describe and locate*) ______________________________

( ) Treated for emotional problems ( ) Considered suicide ( ) Other neurological or psychological problems? ______________________________

**MUSCULOSKELETAL:** In addition to checking the applicable pains, please mark on the body diagrams the location of pain you experience:

( ) Mid back pain
( ) Low back pain
( ) Hip pain
( ) Knee pain
( ) Arm pain
( ) Neck pain
( ) Shoulder pain
( ) Joint pain/stiffness
( ) Walking problems
( ) Runner's knee
( ) Shinsplints
( ) Tennis elbow
( ) Leg pain
( ) Foot pain
( ) Bone spurs
( ) Head pain
( ) Cramps in calves



**NUTRITIONAL:**

Mark your daily intake of sugar: light__________ medium ______________ heavy ______________

How many glasses of pure water do you drink per day? __________

Do you eat red meats? (beet _________ pork ________ liver _________ veal _________)

How many fruits do you eat a day? _______ How many vegetables to do you eat a day?___________

Average daily diet:

*Morning:* ______________________________________________________________

*Afternoon:* ______________________________________________________________

*Evening:* ______________________________________________________________

## MEDICINES / SUPPLEMENTS

Are you taking any of the following on a constant basis?

( ) laxatives ( ) aspirin ( ) sleeping pills ( ) Insulin

List any vitamin supplements you are taking: ______________________

______________________

List any herbs you are taking: ______________________

______________________

Have you received cortisone shots: _____Yes ___No If yes, when and why:______________

______________________

List the current medications you are taking and why: ______________________

______________________

______________________

______________________

## OTHER INFORMATION:

Do you have a regular exercise program? __________No _________Yes

If yes, please list the types of exercise and how often:______________________

______________________

**Please mark your preference:**

| | Most liked | Least liked |
|---|---|---|
| *Season* | | |
| *Taste* | | |
| *Climate* | | |
| *Time of Day* | | |
| *Temperature* | | |

**Do not fill out this portion of questionnaire**

| | | | | | |
|---|---|---|---|---|---|
| Body type: | ______ | Yin / Yang: | ______ | Tone: | ______ |
| Color: | ______ | Firm/Weak: | ______ | Hot/Cold: | ______ |
| Odor: | ______ | Surface / Interior: | ______ | | |

# CLIENT UPDATE

Name:_______________________________________________

Address:____________________________________________

Wk phone__________________ Hm phone__________________

Birth Date:_______________

Physican____________________________________________

Physican phone _____________________

Health Insurance name:______________________________

Insurance Plan name:________________________________

Provider service phone number:_____________________

Claim
Mailing Address:____________________________________

Insured ID number:__________________________________

Insured Policy Number:______________________________

If policy is listed under spouse's name, please provide the following:*
Name:_______________________________________________

Birth
Date:_______________________________________________

===============================================================

Employer's Name:____________________________________

If there has been any physcial condition that needs to be updated please list:______________________________

If there are any other family members who could use the services offered at Adaptive Attitudes in Fitness or Chiropractic care please list their names:

_____________________________________________________

## Services

*Muscle Restoration*
*Massage therapy*
*Neuromuscular Therapy*
*Tai Chi*
*Personal Training*
*Stress Relief Support Meetings*

*Aquatic Exercise*
*Hypnotherapy*
*Yoga*
*Nutritional Support*
*Natural Medicine*
*Weight Loss Program*

# Waiver for Health and Wellness Consulting

1. I fully understand that the attending consultant is not an allopathic doctor (M.D.) and does not pretend to be, but offers health and wellness counseling service.
2. I fully understand the difference between allopathic medicine and wellness consulting.
3. I fully understand that the services provided by this facility are not allopathic, but are holistic or naturopathic in nature.
4. I fully understand the attending consultant performs her services within the parameters of the natural health and wellness care system.
5. I fully understand that the attending consultant does not offer allopathic drugs, surgery, chemical stimulants or radiation therapy. I understand that illness is neither being diagnosed nor treated, but that my wellness is being assessed.
6. I have solicited the attending consultants' services in good faith, exercising my own free will and following the dictates of my own consciousness which allows me to select what I understand is most beneficial to my health. Accordingly, I hold them harmless from any and all liability for any and all complication of any nature should they arise whether to myself or to a minor or an incompetent for whom I am claiming responsibility.
7. I presently seek counsel, advice, opinions, points-of-view and/or programs within the scope of the attending consultants' wellness practice, which is my prerogative. However, if I desire any services not provided by nor within the scope of the attending consultants' wellness practice, which is my prerogative, I fully understand I should seek them elsewhere.
8. I fully understand the services provided by the attending consultants are not generally accepted and/or recommended by allopathic doctors or other conventional health professionals.
9. I fully understand the attending consultants are in no way encouraging me to terminate any previous and/or current therapies allopathic or other doctors have started.
10. I understand that the consultant is neither diagnosing nor treating diseases, but is providing information and therapies to restore natural balance and optimum conditions for health and wellness.
11. I give full faith that I am legally responsible for myself. If I am accompanied by and am signing for a minor or incompetent, I give full faith that I am legally and totally responsible for them.
12. I am neither an employee or any federal, state, or local agency nor am I on my fact finding visit for collection of information concerning this center, and its counseling practices.
13. I give full faith that I have read and understand this document entirely and that I have received a verbal explanation of the same from the attending consultant and that she has satisfactorily answered all my questions and/or doubts.
14. I understand that none of the products recommended are in any way research products. All are products registered with the FDA where necessary in nature.
15. I acknowledge that it is my free will and choice to cancel and/or refuse testing and/or any or all products recommended by this center, and it is the attending consultants' free will and choice to accept or reject any case at any time and for whatever reason without any consequence.
16. I recognize that if I do choose to continue testing and accept products recommended either for myself and/or for any minor and/or incompetent for whom I am claiming responsibility, I do so by my own free will which is both my God-given and constitutional right. Accordingly, I agree to indemnify, protect, save and hold harmless this center from any and all liability for any and all complications of any nature should they arise whether to myself or to any minor and/or incompetent for whom I am claiming responsibility.
17. I am willing and prepared to declare and repeat under oath all of the above statements at the attending consultants' request.

Print your name ____________ Print minor/incompetent name if applicable ____________ Relationship ____________

Please sign your name ____________ Today's Date ____________ Signature of Witness ____________

ALL INFORMATION PROVIDED FOR EDUCATIONAL PURPOSES ONLY