

# Client History Form

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 EMAIL: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
 MOBILE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

To offer you the best possible session, it is important that I know details of your medical history. Please tick which of the following apply to you, and provide any additional information which you believe to be relevant:

<p><b>ALLERGIES</b></p> <p><input type="checkbox"/> I have allergies/suspected allergies to food, environmental substances, medications, etc.) . They are:        .....</p>	<p><b>DETOXIFICATION</b></p> <p><input type="checkbox"/> I have never been on a "Detox" regime. If you <i>have</i> been on a detox regime, please describe the regime you follow (and the date of last regime):        .....</p>	<p><b>HAVE YOUR EVER HAD?</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Acne</td> <td><input type="checkbox"/> Heart Attack</td> </tr> <tr> <td><input type="checkbox"/> Acne Rosacea</td> <td><input type="checkbox"/> Herpes</td> </tr> <tr> <td><input type="checkbox"/> Allergies</td> <td><input type="checkbox"/> High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Inflammation</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Lupus</td> </tr> <tr> <td><input type="checkbox"/> Autoimmune disease</td> <td><input type="checkbox"/> Measles</td> </tr> <tr> <td><input type="checkbox"/> Bacterial Infection</td> <td><input type="checkbox"/> Mental Illness</td> </tr> <tr> <td><input type="checkbox"/> Blood Clots</td> <td><input type="checkbox"/> Migraines</td> </tr> <tr> <td><input type="checkbox"/> Bronchitis</td> <td><input type="checkbox"/> Multiple Sclerosis</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Neurological disorder</td> </tr> <tr> <td><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> Parkinsons</td> </tr> <tr> <td><input type="checkbox"/> Chronic Fatigue</td> <td><input type="checkbox"/> Psoriasis</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Ross River Fever</td> </tr> <tr> <td><input type="checkbox"/> Dermatitis</td> <td><input type="checkbox"/> Shingles</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Skin Rashes/lesions</td> </tr> <tr> <td><input type="checkbox"/> Eczema</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Glandular Fever</td> <td><input type="checkbox"/> Viral infection</td> </tr> </table>	<input type="checkbox"/> Acne	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Acne Rosacea	<input type="checkbox"/> Herpes	<input type="checkbox"/> Allergies	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Asthma	<input type="checkbox"/> Lupus	<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Bacterial Infection	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Migraines	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Neurological disorder	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Parkinsons	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Depression	<input type="checkbox"/> Ross River Fever	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Shingles	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Rashes/lesions	<input type="checkbox"/> Eczema	<input type="checkbox"/> Stroke	<input type="checkbox"/> Glandular Fever	<input type="checkbox"/> Viral infection
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<p><b>BACK/NECK PAIN</b></p> <p><input type="checkbox"/> I am NOT able to lie on my back or stomach for up to one hour.</p> <p><input type="checkbox"/> I have a current back or neck problem. Please describe:.....        .....</p>	<p><b>EMOTIONS</b></p> <p><input type="checkbox"/> I have taken/am taking antidepressants. How would you describe your current emotional state?        .....</p>	<p>Please list other current illnesses:        .....        .....</p>																																		
<p><input type="checkbox"/> I have a history of back or neck problems including injury/operation to my spine? Please describe:        .....</p> <p><input type="checkbox"/> I receive treatment for these problems (or self treat). Please describe:        .....</p>	<p><b>EPILEPSY</b></p> <p><input type="checkbox"/> I have had an epileptic seizure. If so, when was your last seizure, and how frequently have you had seizures?        .....</p>	<p><input type="checkbox"/> I am currently being treated by a health care professional (incl. physiotherapist, chiropractor, or natural therapist). Please describe:.....        .....</p>																																		
<p><b>CHEMICAL EXPOSURE</b></p> <p><input type="checkbox"/> I am a smoker. How many cigarettes a day?.....</p> <p><input type="checkbox"/> I regularly drink alcohol. How many glasses a week?.....</p> <p><input type="checkbox"/> I have been vaccinated</p> <p><input type="checkbox"/> I have taken antibiotics</p> <p><input type="checkbox"/> I have been exposed to a significant amount of chemicals, either through my profession, environmental exposure, hobbies, recreational or prescription drugs (including marijuana), or regular hair colouring. Please provide details:        .....</p>	<p><b>HOT/COLD RESPONSES</b></p> <p><input type="checkbox"/> I like hot drinks (no cool water added)</p> <p><input type="checkbox"/> I strongly dislike cold weather</p> <p><input type="checkbox"/> I strongly dislike cold showers and swimming in cold water</p> <p><b>MEDICATION</b></p> <p><input type="checkbox"/> I am on medication for thinning the blood (Aspirin, Heparin, Warfarin, etc.)?</p> <p><input type="checkbox"/> I have high blood pressure</p> <p><input type="checkbox"/> I am on the contraceptive pill</p> <p><input type="checkbox"/> I am currently taking medication. List type and reason:        .....</p>	<p><b>PREGNANCY</b></p> <p><input type="checkbox"/> I could be pregnant</p>																																		
<p><b>DEHYDRATION</b></p> <p><input type="checkbox"/> How many glasses of water do you drink on average per day (not including other beverages)?</p>	<p><b>PAST OPERATIONS</b></p> <p>Please list <i>all</i> operations (and year):        .....</p>	<p><b>SESSION GOALS</b></p> <p>This is what I'd like to achieve from my Raindrop Technique sessions:        .....</p> <p><b>YOUNG LIVING</b></p> <p><input type="checkbox"/> I am a regular user of <i>Young Living's</i> essential oils</p> <p><input type="checkbox"/> This is <i>not</i> my first Raindrop Technique</p>																																		