AUTHENTIC HEALTH LLC

Confidential Client Health Record for Manual Therapy

Name:	Date of Birth:
Address:	Age:
City:	State/Zip:
Home Phone:	Cell Phone:
Email:	Text?: (circle one) Yes No
Best form of Contact:	Referred By:
Occupation:	Employer:
Marital Status:	Spouse Name:

If seeking help for a child:

Name:	Age:
Overall Health: Excellent Good Poor Other	Specific Concern:
Lives With: Mother Father Stepparent	Legal Guardian Foster Parent (circle)

Check all details that apply to client (adult or child):

Adopted		Autism		Sensory Processing Issues		Hypersensitive Seeking ? (circle)
Prematurity		Head Injury		Learning Problems		Area:
Veteran		PTSD		Stroke		
Car Accident		Sports Injury		Other		Describe:

Specific Reason(s) for Seeking Help:

Additional Thoughts or Goals

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Have you experienced any of these (check all that apply):			
Head Injuries:			
Head Injury		Severe fall or blow to the head	
Concussion		Loss of consciousness	
Speech Issues:			
Lisp/Stutter		Difficulty finding words	
TMJ problems		Slow to begin speaking	
Mood Issues:			
Anxiety		Bipolar disorder	
Loss or change in appetite		Depression	
Suicidal thoughts		Mood swings	
Eye Problems:			
Wears glasses/contacts		Wears reading glasses	
Lazy Eye/Strabismus		Other	
Hearing Difficulties:			
Hearing loss		Ringing in ears/tinnitus	
Fluid in Ears/Tubes		Other: Headaches/Migraines	
Balance Problems:			
Vertigo		Dizziness	
Unsteady gait		Postural Challenge	
Brain Issues:			
Seizures		Confusion	
Loss of memory		Stroke/s	
Ventricular Problems		Other	
Sleep Problems:			
Sleep apnea		Nightmares	
Insomnia		Tired after a full night's sleep	
Restless sleep		Other	
Breathing Difficulties:			
Asthma (medication?)		Seasonal Allergies	
Shortness of Breath		Wheezing	
Allergies:			
Anaphylaxis		Itchy skin/Rashes	
Chronic cough		Food intolerance	
Nasal congestion/sneezing		Sensitivities to fumes/smoke/other	
History of:			
Abuse		Bedwetting	
Trauma		Bullying	

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Client's Birth History and Development Information (if child or long term issues):

Was the pregnancy planned?	
Mother sickness of any kind? Describe:	
Toxemia/Preeclampsia/Viruses? Describe:	
Drugs taken (prescribed or otherwise) before or during labor? Describe:	
Medical Intervention before/during/after? Describe:	
Any difficulty during birthing process? (cord around neck/fetal distress/posterior presentation/etc.)	
Oxygen problems at birth?	
Vaginal or C-section delivery?	
Rapid or long delivery? Forceps? Describe:	
Was baby presented to Mom immediately?	
Was child placed in NICU or PICU for extended time (e.g. was there separation/stress)?	
Medical intervention or difficulty of any kind post-natally? Describe:	
Any serious childhood diseases or surgeries? Please Describe Briefly:	

When did child begin to:	
Sit:	Crawl:
Take Steps:	Climb/Run:
How long did they crawl?	Did they enjoy tummy time?
When did child begin to say words?	Two/three word sentences:
Communicate well:	Any speech problems?:
Any Phobias?	Any texture sensitivities (food/clothes)?

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Behavioral Information:

History or current: Check all that apply; two checks for significant problems

Accident prone		Lacking confidence		Clumsy	
Letter/number reversal		Poor reading skills		Difficulty concentrating	
Daydreams excessively		Mood swings		Over or under active	
Difficulty focusing eyes		Eyestrain/rubs eyes a lot		Rests head on arms	
Fear of speaking in group		Phobias		General anxiousness	
Poor at sports/rhythm		Poor balance		Short attention span	
Trouble with right/left		Dizziness/vertigo		Test/performance anxiety	
Timid/shy		Slow to complete work		Trouble remembering	
Poor spelling		Poor direction following		Handwriting challenges	
Challenge with math/logic		Impulsive		Restless/Impatient	
Unable to structure day		Frequent headaches		Frequent constipation	

Any other information that would be pertinent to us or any information to expand from above checklists:

Client Signature: _____ Date: _____