Child 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 and your family on your journey toward health and wellness.

Client's Name:_____ DOB: ____/____/__ Age: ____ Male Female

Parent/Legal Guardian Name: _____

Parental Marital Status: S M D W Separated

Does anyone else share legal custody of child? _____

Primary Address: _____

Primary Telephone Number: _____ Other:_____

Can we leave a message: Yes No

Email Address: _____

Check here to opt out of receiving email notifications of upcoming events, workshops, and special discounts on services.

Emergency Contact: _____ Telephone: _____

How did you hear about us? _____

Physical Health

Height: __ ft. __ in Current Weight: _____ lb Are there presently any weight related challenges? _____

Current treating physician or other health care professionals:

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: _____

_____

_____

_____

Health History

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

_____

_____

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

To the best of your knowledge, has there been any long-term exposure to chemicals, pesticides, herbicides, radiation, solvents, or heavy metals? Y / N

If yes, please explain:_____

DENTAL: Are there currently or have there ever been metal dental fillings? Y / N
Any tooth extractions? Y / N
Please explain any current dental
difficulties:_____

Bowel movements: >1/day____ 1/day____ Every 2 days____ 3/week____ 2/week____Other_____

Current Medications/Supplements:
Please include over the counter medications and supplements

Medication/Supplement	Dosage	Purpose	Side Effects

Menstrual History:

Date of last menstrual cycle: _____

Regular cycles? 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_____

Currently pregnant? Y / N

Birth Control Information:

Is there any history of hormonal-type birth control (patch, pill, injection, implant, IUD)? Y / N

Current hormonal-type birth control use? Y / N Total years taken:_____

Reason for starting: PMS ____ Irregular cycle ____ Birth Control ____ Other _____

Appetite and Eating:

Please describe appetite: Excellent Good Fair Poor
Has there been a recent change in eating habits: Yes No
If yes, please describe changes _____
_____

Current 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: _____
_____
_____

Vegetarian or vegan? Yes No
If yes, are any of the following consumed?

Eggs	Yes	No	Cheese	Yes	No
Yogurt	Yes	No	Milk	Yes	No
Poultry	Yes	No	Fish	Yes	No

Please list any known food allergies or sensitivities:_____
_____
_____

Disliked Foods: _____
_____
_____

Favorite foods or snacks:
_____
_____

Are any foods avoided because of cultural or religious practices? Yes No
If yes, please specify:_____

Cigarette smoking: Yes No
Quantity: Less than 10/day 10-20/day More than 20/day
If quit, how long ago? _____

Alcohol consumption:
Daily Weekly Monthly Never

Level of physical activity? Low Moderate High
Please list types of exercises/activities that are enjoyed: _____

COMMON COMPLAINTS SURVEY: PLEASE FILL OUT COMPLETELY

Please circle relevant symptoms and explain in space given.

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 _____

Other _____

Please list the main health complaints in order of importance:

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

Onset:_____ How often is it a problem?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have been tried?_____

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

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

Onset:_____ How often does is it a problem?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have been tried? _____

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

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

Onset:_____ How often does is it a problem?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have been tried?_____

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

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

Onset:_____ How often is it a problem?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have been tried?_____

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

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

Onset:_____ How often is it a problem?_____

Does anything make it feel better?_____

Does anything make it feel worse? _____

What other treatments have been tried?_____

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

Mental/Emotional

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

What would you like to see different 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 and why?_____
_____
_____

What has not been helpful and why not? _____
_____
_____

Significant family history and dynamics:_____
_____
_____
_____

Significant academic history and/or challenges: _____
_____

_____

_____

Leisure and extracurricular pursuits: _____

_____

Current Symptoms: (Check all that apply)

___ Long periods of sadness ___ Intrusive memories ___ Peer difficulties

___ Loss of interest ___ Racing thoughts ___ Mood swings

___ Fatigue ___ Physical pain ___ Startle easily

___ Change in sleeping or eating ___ Memory challenges ___ Hearing voices

___ Nightmares ___ Thoughts of suicide ___ Spacing out/blacking out

___ Loss of time ___ Self-harm behavior ___ Anger

___ Feeling disconnected from body ___ Substance Abuse ___ Seeing things others don't

___ Difficulty feeling emotions ___ Feeling disconnected from self, others, or body

___ Difficulty concentrating ___ Panic Attacks ___ Defiant Behavior

___ Physical aggression ___ Change in Toileting Habits

___ Hyperactivity ___ Destructive of Property ___ Change in Academics

___ Separation Anxiety ___ Learning Disability ___Developmental Delays

___Other Symptoms _____

_____

_____

Have any of the following events been experienced? If yes, please briefly 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 Witnessing combat:_____
_____

Yes No Ritual abuse or torture:_____
_____

Yes No DFCS or legal system involvement:_____
_____

Yes No Grief and loss:_____
_____

Yes No Other Traumas (please list):_____
_____

Perceived impact of these experiences _____

_____
_____

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

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

_____
Client Signature Date

_____
Parent/Guardian Signature Date

_____
Parent/Guardian Signature Date