Client History and Information

Thank you for choosing TRU Integrative Health and Wellness, LLC. 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 Name:_____ DOB: ____/____/____ Age: _____

❑ Male ❑ Female Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Separated

Address: _____

Primary Telephone Contact:_____ Can we leave a message? ❑ Yes ❑ No

Email Address: _____ Can we contact you by email? ❑ Yes ❑ No

Can we send you a text message regarding scheduling issues? ❑ Yes ❑ No

Local Emergency Contact: _____ Telephone: _____ Relation: _____

How did you hear about us? Please be as specific as possible. _____

❑ Check here to opt out of receiving notification via email of upcoming events, workshops, and discounts.

Physical Health

If you are seeking support for mental, emotional, or relational concerns, this section is optional.

Primary physical complaints: _____

_____

Height: __ ft. __ in Current Weight: _____ lb Lowest Adult Weight: _____ lb

Ideal Weight: _____ lb Are you presently gaining or losing weight? _____

Would you like help losing or gaining weight? ❑ Yes ❑ No

Are you currently under the care of any other physician or health care professional? ❑ Yes ❑ No

If yes, Doctor's name: _____ Specialty:_____

Reason for care: _____ Date of last visit:_____

Other current treating doctors: _____

_____

Health History:

Illness or Injury Approx. Date Complications/Comments Full Recovery? ❑ Yes ❑ No

_____

_____

_____

Surgery Approx. Date Complications/Comments Full Recovery? ❑ Yes ❑ No

_____

_____

_____

Family History: Cancer__ Diabetes__ Heart Problems__ Mental Illness__ Other _____

Please explain: _____

_____

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

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_____

Current Medications/Supplements:

Please include prescription drugs as well as over the counter medications and supplements.

Medication/Supplement	Dosage	Purpose	Side Effects

Menstrual History:

Date of last menstrual cycle:_____ Are your cycles regular? ❑ Yes ❑ No

If no, please explain:_____

Menstrual Cramping: ❑ Yes ❑ No If yes: Slight ____ Moderate ____ Severe ____

Other PMS symptoms: ❑ Yes ❑ No Please indicate: Bloating ____ Cravings ____

Back Pain ____ Moodiness ____ Other_____

Are you currently pregnant? Y / N Weeks: ____ Complications: _____

If pregnant, are you interested in information about natural pregnancy and/or childbirth? Y / N

Birth Control Information:

Have you ever used hormonal-type birth control (ie: 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 _____

Appetite and Eating:

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 _____

_____

Do you struggle with restrictive or binge eating? _____

Are you currently or have you ever received treatment for an eating disorder? _____

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:_____

Are you a vegetarian or vegan? ❑ 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 known food allergies or sensitivities:_____
_____
Are there foods you dislike?_____
What are your favorite foods or snacks?_____
Do you avoid eating any foods because of cultural or religious practices? ❑ Yes ❑ No
If yes, please specify:_____

Have you ever or do you currently smoke? ❑ Yes ❑ No If quit, how long ago? _____
Quantity: ❑ Less than 10/day ❑ 10-20/day ❑ More than 20/day

How often do/did you drink alcoholic beverages? ❑ Daily ❑ Weekly ❑ Monthly ❑ Never
Is your drinking problematic for you? ❑ Yes ❑ No Are you currently in recovery? ❑ Yes ❑ No

Do you currently use any other drugs? (please specify) _____
Do you have a history of using drugs? ❑ Yes ❑ No Are you currently in recovery? ❑ Yes ❑ No

Are you able to do physical activity? ❑ Yes ❑ No If so, how often are you active? _____
Please list types of exercises/activities you enjoy_____

Symptom Profile: PLEASE FILL OUT COMPLETELY

Please circle the symptoms that are relevant to you and list approximate date of start and frequency of experience in space given.

Suicidality: Y/N If so, please indicate: Thoughts: **Y/N** Plan: **Y/N** Intent: **Y/N** Hist. of attempts: **Y/N**

Immediate need for food, shelter, safety, or medical care (please describe): _____
_____

Loss of Interest _____ Hopelessness _____
Grief/Loss _____ Depressed Mood _____
Fatigue/Low Energy _____ Difficulty Concentrating _____
Recent increased or decreased need for sleep _____
Recent change in appetite (please describe) _____
Desire/Acts of self-harm (please describe) _____
Mood Swings _____ Expansive/Elevated Mood _____
Risky Behavior _____ Irritability _____
Anger _____ Impulsiveness _____
Thoughts/Desire to harm others: _____
Anxiety/Worry _____ Racing Thoughts _____
Neck stiffness/pain _____ Back stiffness/pain _____
Pain elsewhere in the body (please describe) _____
Difficulty falling asleep_____ Difficulty staying asleep _____
Tired upon awakening _____ Nightmares _____
Digestive difficulties (please describe)_____
Allergies/Sinus Problems _____ Headaches _____
Memory Challenges _____ Spacing out/Blacking out _____
Loss of Time _____ Dissociation _____
Flashbacks _____ Startle Easily _____
Emotionally Numb _____ Panic _____
Substance Abuse _____ Challenges with Food/Eating _____
Weight Related Issues _____ Sexual Issues _____
Hearing things others don't _____ Seeing things others don't _____
Relationship Difficulties (please describe) _____
Other (please list): _____
_____
_____
_____

Mental/Emotional/Relationship Health

If you are seeking support around solely physical concerns, this section is optional.

Please describe your presenting concerns in as much detail as possible: _____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

Have you been in therapy before? (Please list) _____

_____

_____

Have you ever been in an inpatient or residential psychiatric facility? (Please list and describe):

_____

_____

Current Psychiatric Medications:_____

_____

Past 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? _____

_____

Based on your past experiences, are there things that you know you specifically want or don't want from your therapist at TRU? _____

_____

_____

Client History:

Please briefly describe the family you grew up in (members, dynamics, experiences, etc.):

_____

_____

_____

_____

Please briefly describe your current family: _____

_____

_____

_____

Other significant relationship history: _____

_____

_____

Who provides you with emotional support?_____

Educational level/history: _____

Occupational history: _____

Leisure interests: _____

Spiritual, religious, and cultural practices: _____

_____

Personal strengths: _____

Personal challenges or weakness: _____

Are you now experiencing, or have you ever experienced, any of the following events? If yes, please list age of occurrence, by whom, and whether the event occurred once or more.

❑ 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) :_____

_____

Please thoroughly describe how you believe these experiences have impacted or affected you:

_____

_____

_____

_____

_____

What else do you want to be sure that we know about you? _____

_____

_____

_____

Thank you for filling this document out thoroughly! Your time and attention will truly help us to help you to the best of our ability!

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

_____

Client Signature Date