



The Healing Company
 Shop 15, St Kevin's Arcad, Karangahape Road, Auckland
 Ph: 021 259 0811 : www.thehealingcompany.co.nz

CLIENT HISTORY (CONFIDENTIAL-for Practitioner's use only)

Name _____ Date _____

Address _____

Phone: Home _____ Work _____

E-mail _____ D.O.B. _____

Referred By _____ Occupation _____

Relationship Status _____ # Children _____ Height _____ Weight _____

Reason for Visit _____

Current Medications _____

Current Complementary Therapies / Supplements _____

Eating Habits / Diet _____

Amount Daily Intake: Water _____ Caffeine _____ Alcohol _____ Cigarette / Tobacco _____

Exercise Routine _____

Please mark the following areas of diseases or symptoms as 'C' for current, 'P' for past, and 'CH' for chronic.

| | | | |
|--------------------------|-------------------------|------------------------|-------------------------|
| EMOTIONAL / PSYCH | Hyperthyroid | Heart Attack | URINARY |
| Depression | Hypothyroid | Heart Failure | Bladder Infection |
| Eating Disorder | NEUROLOGICAL | Hypertension | Kidney Stones |
| Mood Swings | Epilepsy | Stroke | REPRODUCTIVE |
| Substance Abuse (type) | Dizziness | RESPIRATORY | Sex. Trans. Dis. (type) |
| AUTO-IMMUNE | Insomnia | Bronchitis | Endometriosis |
| AIDS / HIV | Migraines | Emphysema | Pregnancies (# & 'C') |
| Allergies | MUSCULO-SKELETAL | Pneumonia | Miscarriage (#) |
| Cancer | Arthritis | Tuberculosis | Abortion (#) |
| Fatigue | Back Pain | DIGESTION | |
| Fever (chronic) | Carpal Tunnel | Constipation (chronic) | |
| Fibromyalgia | Gout | Diabetes | OTHER: |
| Fungal Infections (type) | Skin Disorder (type) | Diarrhea (chronic) | |
| Herpes (type) | ENT | Gastritis | |
| Lyme Disease | Earaches (chronic) | Hepatitis | |
| Mononucleosis | Headaches | Hypoglycemia | |
| ENDOCRINE | Jaw Pain | Jaundice | |
| Adrenal Insuf. | CARDIOVASCULAR | Liver Disorder | |
| Pituitary Dysf. | Angina | Ulcers | |



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| | | | | |
|---------------------------|-----------------------|-----------------------------|-------------------|----------------|
| Crying spells | Change in sleep | Family problems | Angry outbursts | Loneliness |
| Relationship Problems | Increased nervousness | Eating changes | Social problems | Seeing things |
| Headaches | Work problems | Trouble concentrating | Sadness | Hearing things |
| Change in sexual activity | Suicidal | Feeling out of control | Homicidal | Unmotivated |
| Loss of trust in others | Financial problems | Panic attacks | Weight loss/ gain | |
| Forgetfulness | Violent feelings | Increased alcohol/ Drug use | Confusion | |

Please list any traumatic or life threatening events that occurred in your life, and when they happened:

What do you hope for and what are your expectations from this session and long- term?

Is there anything else you want to share or want me to know?
