Holistic Health Practice
New Client Questionnaire

Client Information

Date: _____

Name: _____

Referred by: _____

Birthdate: _____

Pronouns you use to describe yourself (circle one):

She/Her He/His They/Theirs Ze/Hir

My name only Other_____ Decline to answer

Single Married Widowed Separated Divorced

Contact Information

Address: _____

_____

Best Contact #: Home Cell Work

_____

Email: _____

Occupation: _____

Employer: _____

Employer Ph# : _____

Medical History

Date of last physical examination

_____

Your principal health care provider

_____

In Case of Emergency, Contact

Name: _____

Relationship: _____

Ph#: _____

Reason For Visit

_____

_____

_____

Medical History

Check symptoms you currently have or have had in the past year.

General

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Weight Gain
- ☐ Numbness

Eye/Ear/Nose Throat/Gums

- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Vision – Flashes/Halos
- ☐ Ringing in ears
- ☐ Ear Ache/Ear discharge
- ☐ Loss of hearing
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Persistent cough

Gastrointernal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in Moles
- ☐ Scars
- ☐ Sore that won't heal

Cardiovascular

- ☐ Chest pain
- ☐ High/low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Women Only

- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other _____

Date of your last period _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Men Only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other _____

Number of children _____

Check conditions you have or have had in the past:

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Medications/Allergies

List medications or supplements you are currently taking: _____

_____

List allergies to medications or substances: _____

_____

Energy levels and general life attitude

- ☐ Good appetite
- ☐ Low appetite
- ☐ Always hungry
- ☐ Difficulty sleeping
- ☐ Depression
- ☐ Mental sluggishness
- ☐ Easily tired
- ☐ Positive life attitude
- ☐ Negative life attitude
- ☐ Feel overwhelmed
- ☐ Enjoy physical activity
- ☐ Wake up feeling tired
- ☐ Wake up ready for the day

Substance Use

Check which substances you use and describe how much and how frequent

- ☐ Caffeine _____
- ☐ Recreational drugs _____
- ☐ Tobacco _____

Occupational Hazards

Check if your work or lifestyle exposes you to the following:

- ☐ Stress
- ☐ Heavy lifting
- ☐ Hazardous substances
- ☐ Sitting or standing for long periods at desk or pc terminal
- ☐ Carpal tunnel syndrome
- ☐ Other _____
- ☐ Other _____

Exercise

Type of exercise you do. Please indicate how often and how long:

- ☐ Walking outdoors _____
- ☐ Treadmill _____
- ☐ Running _____
- ☐ Bicycle _____
- ☐ Aerobic classes _____
- ☐ Weight training _____
- ☐ T'ai Chi _____
- ☐ Yoga _____
- ☐ Swimming _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Family History

Mother Alive Deceased Present health or cause of death _____

Father Alive Deceased Present health or cause of death _____

Sisters Number ____ Alive Deceased Present health or cause of death _____

Brothers Number ____ Alive Deceased Present health or cause of death _____

Family Illnesses

Check illnesses which have occurred in any of your blood relatives:

- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Stroke
- ☐ Nervous Illness
- ☐ Cancer
- ☐ Diabetes
- ☐ Allergy
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Epilepsy
- ☐ Asthma
- ☐ Liver Disease
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Signature

I certify the above information is correct to the best of my knowledge. I will not hold Holistic Health Practice or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Holistic Health Practice

Consent Form

Name _____

Date _____

Client Consent to Treatment

◊ I, _____ certify that I am a competent adult of at least 18 years of age or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment. This Informed Consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assignees.

◊ I certify that I am in adequate physical, emotional and mental health to participate in treatments at Holistic Health Practice (If not, please specify on the opposite side). I acknowledge that should this information change, it is my sole responsibility to notify the therapists/instructors/doctors at HHP.

◊ I, _____, consent to and authorize the Holistic Health Practice staff to perform holistic treatment upon me as specified and recommended by my healer. This treatment may include energy and vibrational healing, musculoskeletal massage and manipulation, Chiropractic adjustment, acupuncture and spiritual counseling/coaching.

◊ The nature of the service/session has been explained to me and/or is available to me in writing and any questions I had regarding the treatment(s) have been answered to my satisfaction.

◊ I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. Possible side effects may include dizziness, disorientation,
emotional breakthroughs, physical, mental and/or emotional vulnerability.

◊ Alternative means of treatment and their risks have been explained to me, and I understand that I have the right to refuse the treatment.

◊ No guarantee, warranty or assurance has been made to me as to the results that may be obtained.

◊ I agree to adhere to all safety precautions and regulations during my treatments/sessions at Holistic Health Practice.

Client Signature

_____

Date _____/_____/_____

Holistic Health Practice

Name_____

Date_____

Additional Client Information

Confidentiality

Information shared with Holistic Health Practice (HHP) through its Practitioners is confidential, except in the following circumstances:

- Diagnosis and dates of service shared with client insurance company
- Mandated reporting of physical or sexual abuse of children
- Threats of suicide or homicide
- Cases where a client signs a release of information
- Information necessary for supervision or consultation

Emergency Situations

Outside of business hours, in the case of an emergency, an HHP client should call 911 or whatever emergency service is available in the client's appropriate community, and should go immediately to the closest emergency room. When the contact phone number of an HHP practitioner has been provided to a client, the client may elect to inform the practitioner after emergency services have been contacted.

Client Accounts and Fees

Holistic Health Practice services are due at the time of service. Fee amounts can be confirmed before actual service date from Front Office Administration. HHP does not process insurance claims. Diagnosis codes can be assigned to sessions involving body work that the client can, in turn, submit to an insurance company. Invoices are sent to a client through email, and can be printed
upon request.

Credit card information will be collected and kept on file at the time a client account is established. If the client elects to make payment per session, the client will be consulted prior to charging the card on file.

A 24-hour notice of cancellation of appointments is required. Full payment of a scheduled session will be due if an appointment is missed or cancelled late, and the credit card on file will be charged, unless the client arranges for an alternate form of payment.

Kurt Hill Disclaimer

If applicable, I understand that Kurt Hill is not a licensed physician. Mr. Hill does not dispense medical advice or prescribe the use of any technique as a form of treatment for physical or medical problems without the advice of a physician-either directly or indirectly. As a licensed professional counselor, a licensed massage therapist, a Master of Divinity and ordained minister, his intent is to offer information of a general nature to help his clients in their quest for emotional, mental, physical, and spiritual well-being and Mr. Hill assumes no responsibility for how the client may use this information.

Acknowledgement of Additional Information

I have read and understand with the above sections on Confidentiality and Emergency Situations and agree to the financial terms of HHP policy.

Client Signature:_____Date_____