Staci L. Ross, M.A., L.M.F.T.

Lighthouse Wellness Center

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Confidential Client History

Name:_____

Address:_____

City, State, Zip:_____

Telephone: Home:_____Work_____Cell:_____

Email:_____ Birthdate/Time/Place:_____

Age:_____ Marital Status:_____ No. of Children:_____ Occupation_____

Is there any possibility that you are pregnant?_____ Are you nursing?_____

Family Physician (name and number):_____

How did you hear about Lighthouse Chiropractic and Wellness Center?_____

Objectives

Please check the items that reflect your main objectives:

___I want an alternative approach to allopathic medicine for managing illness and disease
___I want to improve my general health and wellness and reduce my vulnerability to illness and disease
___I want to improve my lifestyle and dietary practices to improve my health
___I want to change my habits and behavioral patterns to improve myself and my relationships with others
___I want to manage stress, tension and worry to attain a more stable emotional nature

Review of Concerns

List your chief complaints and any other significant symptoms that you are concerned about. If you have been diagnosed with any disease or condition, list them as well.

Physical Health Concerns:_____

Psychological/Emotional Concerns:_____

Diagnosed Conditions:_____

Current Digestive and Psychological/Emotional Health Challenges-circle

Abdominal	Lethargy	Depression	Self-Destructive
Belching	Bloating	Sadness	Irritable
Regurgitation	Constipation	Worry	Anger
Gas	Diarrhea	Anxiety/Fear	Resentment
Heartburn	Unformed Stool	Overwhelm	Jealousy/Envy
Vomiting	Rectal pain	Spacey	Critical
Nausea	PMS	Insomnia/light sleep	Intense
Heavy after eating	Heavy menstrual flow	Foggy	Difficult making decisions

Other Current Health Challenges

Physical:
Psychological/Emotional/Spiritual:

Health Goals:

Physical:
Psychological/Emotional/Spiritual:

General Health & Lifestyle Patterns (circle and describe)

Caffeine: Yes/No
Alcohol: Yes/No
Tobacco: Yes/No
Other Addictive Substances: Yes/No
Exercise: Yes/No
Water: Yes/No
Allergic reaction to food, drugs, environmental: Yes/No
Work Stress: Yes/No (1-least, 5=most) 1 2 3 4 5 Level of satisfaction: 1 2 3 4 5
Sexually active: Yes/No (1-least, 5=most) Libido 1 2 3 4 5 Level of satisfaction 1 2 3 4 5
Spiritual practice: Yes/No (Describe)
Meditation: Yes/No
Sleep: Bedtime? Risetime? Awakenings? Naps? Rested upon waking: Yes/No

Dietary Patterns

What kind of tastes do you prefer? (Please circle one or more of the following)

Sweet Sour Salty Pungent Bitter Astringent

Any current or past chronic eating disorders or other food related issues?_____

Diet-Describe What is Typical (time of day/food/beverage)

Breakfast:
Snack:
Lunch:
Snack:
Dinner:
Snack:
Water and beverages:
Eating Routines: (ex. Skipping, Standing, in Car…)

Current Medications, Herbs, Supplements

Medication: (Including birth control/hormone replacement therapy)
Supplements:
Herbs:

Past Medical History-Include Dates and Details

Diagnosed Illnesses:
Hospitalizations:
Operations:

Family History-Circle and Indicate Family Members

Cancer:
Diabetes:
High Blood Pressure:
Heart Disease:
Stroke:
Mental Disorders:
Other:

For Women Only

Menstrual History: Heavy or Light, Cycle: Less than 28, 28, 30+ (days). PMS Y/N Menopause Y/N