Galter LifeCenter
The science of feeling better

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INTEGRATIVE THERAPY DEPARTMENT CLIENT HEALTH HISTORY

Your confidential health history is being requested for your health and safety. Integrative Therapy affects a variety of body systems. Your response on the following questions will help us create a safe session for you. In some cases, certain health conditions may require adaptation of application and/or a health care provider's release. Your cooperation and understanding is appreciated.

NAME _______________ DATE _______________

ADDRESS _______________

EMAIL ADDRESS _______________ DATE OF BIRTH _______________

TELEPHONE (BEST NUMBER) _______________ TELEPHONE (ALTERNATE) _______________

OCCUPATION _______________

EMERGENCY CONTACT (RELATIONSHIP) _______________ CONTACT TELEPHONE _______________

Are you currently under the care of a physician? ❑ Yes ❑ No

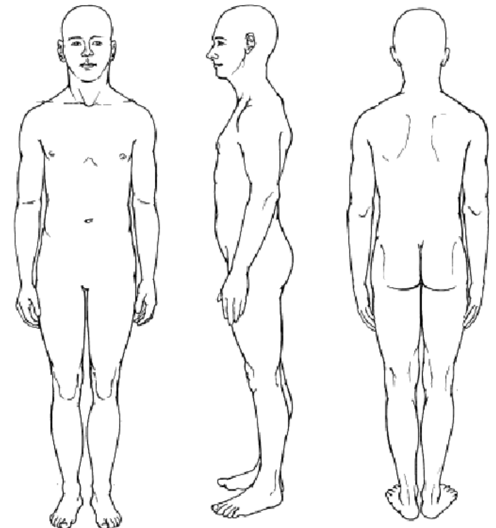
If yes, please indicate your condition: _______________

Physician's name: _______________ Telephone: _______________

Do you wear orthotics our use any aids for mobility. ❑ Yes ❑ No If yes, please describe: _______________

On a scale of 0 (no tension) to 10 (high levels of stress), please indicate the amount of tension in your life: ________

On the figures to the right, please indicate the areas where you carry tension, experience discomfort or hold stress.



What is your reason for today's visit? _______________

Have you had any accidents? ❑ Yes ❑ No

If yes, please provide details: _______________

Do you consider yourself fully recovered? ❑ Yes ❑ No

Have you been hospitalized in the past two years? ❑ Yes ❑ No

If yes, please indicate condition: _______________

Are there any areas you do not want addressed during your session?

____

Do you take any medications/herbs (prescription or over-the-counter)? ❑ Yes ❑ No

Please list: _______________

General Medical Information

For your safety, our therapists must be aware of any history of the following medical conditions. Please indicate if you have ever experienced any of the following:

MUSCULOSKELETAL
- ❑ Fibromyalgia
- ❑ Myofascial Pain Syndrome
- ❑ Spasms/Cramps
- ❑ Sprains/Strains
- ❑ Osteoporosis
- ❑ Postural Deviations
- ❑ Gout
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Disc Herniation
- ❑ Bursitis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Torticollis
- ❑ Whiplash Syndrome
- ❑ Carpal Tunnel Syndrome
- ❑ Sciatica
- ❑ Thoracic Outlet Syndrome
- ❑ Headache
- ❑ Shin Splints
- ❑ Jaw Pain or Clicking
- ❑ Other

NERVOUS SYSTEM
- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Bell's Palsy
- ❑ Neuritis
- ❑ Spinal Cord Injury
- ❑ Trigeminal Neuralgia
- ❑ Seizure Disorders
- ❑ Numbness/Tingling
- ❑ Dizziness
- ❑ Anxiety/Depression
- ❑ Addiction
- ❑ Diagnosed Mental Illness
- ❑ Other

DIGESTIVE
- ❑ Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Acid Reflux
- ❑ Crohn's Disease
- ❑ Diarrhea
- ❑ Gas/Bloating
- ❑ Indigestion
- ❑ Other

SKIN
- ❑ Bruise Easily
- ❑ Scar Tissue
- ❑ Dermatitis/Eczema
- ❑ Psoriasis
- ❑ Open Wound or Sore
- ❑ Rashes
- ❑ Infectious Condition
- ❑ Allergies or Sensitivities
- ❑ Other

CIRCULATORY
- ❑ Anemia
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Low Blood Pressure
- ❑ Raynaud's Disease
- ❑ Varicose Veins
- ❑ Heart Condition
- ❑ Blood Clots/Phlebitis
- ❑ Diabetes
- ❑ Stroke
- ❑ Swollen Ankles
- ❑ Other

RESPIRATORY
- ❑ Pneumonia
- ❑ Sinusitis
- ❑ Asthma
- ❑ Difficulty Breathing
- ❑ Wheezing
- ❑ COPDs
- ❑ Other

OTHER
- ❑ Insomnia
- ❑ Sleep Apnea
- ❑ Anxiety/Panic Attacks
- ❑ PMS
- ❑ Edema
- ❑ Postoperative Situation
- ❑ Cancer (current or historical)
- ❑ Bladder Infection
- ❑ Chronic Fatigue
- ❑ Kidney Disease
- ❑ Autoimmune disorders
- ❑ Diabetes
- ❑ Allergies ________________
- ❑ Other ___________________

❑ I have no history of any of the above conditions

Are you pregnant? ❑ Yes ❑ No Due date? ____________________ Are you receiving prenatal care ❑ Yes ❑ No

If yes, are you experiencing any of the following?

- ❑ Low back pain
- ❑ Mid back pain
- ❑ Low weight gain
- ❑ High weight gain
- ❑ Protein in urine
- ❑ Visual disturbances
- ❑ Systemic edema
- ❑ Diagnosed maternal illness
- ❑ Multiple gestations
- ❑ Violent headaches
- ❑ Severe vomiting
- ❑ Frequent urination
- ❑ Pelvic pain
- ❑ High blood pressure
- ❑ Excessive hunger or thirst
- ❑ Cramping or contractions

Habits / Lifestyle

What physical activities do you do on a daily or weekly basis? ____

Hobbies? ____

Do you: Smoke? _______________/day Drink? _______________/week Consume caffeine? _______________/day

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I understand and agree to the following:

All the information I have provided is correct and current to the best of my knowledge, and I will update my health history form with any changes in my health and medications.

Signature ____ Date ______________________________

Parent/Guardian Signature __________________________________ Date ______________________________