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CLIENT HISTORY CHECKLIST

Name: _____

Address: _____

Date of Birth: _____

Date: _____

Phone: Day _____

Phone: Night _____

Email: _____

Referred by: _____

Please note that this intake form could be considered “long”, but the more information I have about you the more comprehensive a plan we can create for your consultation. Please feel free to skip any sections that cause stress or seem irrelevant. All records are completely confidential and will be released only with your permission. If permission is given all submissions are given with the name removed from the record.

Please list the problem(s) or focus you would like me to help you with and include how long you have had them, what YOU think caused them, what time of day they are better or worse, and what makes them better or worse.

What kinds of treatment(s), if any, have you tried?

Blood Type: Blood Pressure:

Do you tend to be hot or cold in bodily temperament? _____

Difficulty falling asleep? _____ Difficulty staying asleep? _____

Number of hours of sleep per night, sleep and wake up times:

What is your general disposition and physical state upon waking? _____

What is your down time or most difficult time of day? _____

Best time? _____

List major illnesses you have had (Circle and include age): Cancer Diabetes Hepatitis
High Blood Pressure Heart Disease Pneumonia Rheumatic
Fever Thyroid Disease Seizures Venereal Disease Other

Please list your parents= and grandparents= health issues, if known. Diabetes Cancer
Stroke High Blood Pressure Heart Disease Seizures Asthma Allergies Tuberculosis
Pneumonia _____

List any surgeries or significant traumas such as auto accidents, falls, etc. (Include age):

Known Allergies: (drugs, chemicals, foods):

How many packs of cigarettes do you smoke a day? _____

How often and how do you exercise? _____

How often do you have a bowel movement? 3x/day, 2x/day, daily, every other day, (other)
Is it loose or hard? _____ Is it hot or unusually smelly? _____

Urination. Do you need to urinate in middle of night? _____ Dribbling? _____ Incontinence? _____
Hot, dark or smelly? _____

Do you have a bitter, metallic, sweet, or other taste in your mouth?

Do you itch? _____ Where? _____

Write briefly how you feel about your body image and anything of note in this area. _____

Women only: Have you begun or experienced menopause? _____

Hot Flashes? _____ Night Sweats? _____

Have you ever received Silicone or Saline Implants? _____. When? _____.

Check one column(s) that most commonly describes the frequency of the condition. Please focus on recent or very consistent long-term experiences.

	THIS MONTH	OFTEN	SOME	RARE
Headache or head pain. Where?				
Migraines.				
Pain in the eyes, ears, nose, or throat. Where?				
Pain above the waist. Where?				
Tension in the neck or across the shoulders.				
Twitching of the eyes, ears, face, calves, or feet.				
Burning or itchy eyes.				
Sinus pain or infections.				
Depression.				
Genital Herpes, Gonorrhea, Chlamydia, other.				
Hepatitis. Jaundice				
Often Angry. Do you express it? How?				
Adrenal deficiencies or feel stressed out.				
Cold feeling <input type="checkbox"/> or cold to the touch <input type="checkbox"/> .				
Diminished recall.				
Herniated disks.				
Frequent <input type="checkbox"/> , slow <input type="checkbox"/> , or suppressed urination <input type="checkbox"/> .				
Exhausted <input type="checkbox"/> or tired <input type="checkbox"/> .				
Aching bones <input type="checkbox"/> . Low back <input type="checkbox"/> or spinal pain <input type="checkbox"/> .				
Weakness <input type="checkbox"/> or pain <input type="checkbox"/> in knees <input type="checkbox"/> or ankles <input type="checkbox"/> .				
Recent loss of hearing <input type="checkbox"/> or eyesight <input type="checkbox"/> .				

Night sweats.				
Asthma or wheezing <input type="checkbox"/> . Shortness of breath <input type="checkbox"/> .				
Dizziness <input type="checkbox"/> or blurring of vision <input type="checkbox"/> .				
Tinnitus or ringing in ears. Sudden onset <input type="checkbox"/> or gradual <input type="checkbox"/> .				
Often fearful or anxious. Any particular fears?				
Dry nose <input type="checkbox"/> , throat <input type="checkbox"/> , skin <input type="checkbox"/> or hair <input type="checkbox"/> . Itching from dryness <input type="checkbox"/> .				
Lack of sweat, even when hot <input type="checkbox"/> . Excessive sweating <input type="checkbox"/> .				
Enlarged or hard lymph nodes.				
Moles <input type="checkbox"/> or warts <input type="checkbox"/> . Where?				
Congestion of nose, sinuses, or throat.				
Shallow breathing <input type="checkbox"/> . Harsh breathing <input type="checkbox"/> .				
Varicose veins.				
Nasal or intestinal polyps				
Thin, delicate skin. Painful skin cracking.				
Skin rashes.				
Constipation, spastic colon, or irritable bowels.				
Often Critical <input type="checkbox"/> . Often Sad <input type="checkbox"/> . Mental fixations <input type="checkbox"/> .				
High blood pressure				
Heartbeat: Rapid, irregular or palpitations.				
High cholesterol. _____				
Feeling faint, dizzy, or disoriented when startled				

or excited.				
Nightmares.				
Easily distracted <input type="checkbox"/> . Disturbed Thinking <input type="checkbox"/> .				
Fullness or bloating of stomach				
Gas above navel <input type="checkbox"/> , gas below navel <input type="checkbox"/> , belching <input type="checkbox"/> , farting <input type="checkbox"/> or hiccups <input type="checkbox"/> .				
Nausea <input type="checkbox"/> . Vomiting <input type="checkbox"/> . Diarrhea <input type="checkbox"/> .				
Canker sores, mouth sores, swollen, sore or bleeding gums.				
Chronic bleeding or hemorrhages. Bruises.				
Hemorrhoids <input type="checkbox"/> . Varicose Veins <input type="checkbox"/> .				
Poor appetite _____. Very hungry _____				
Arthritic or rheumatic pain.				
Generalized puffiness or edema.				
Obsessive desire for or avoidance of food.				
Cravings for sweet or starchy foods.				
Often Worried. Obsessive.				

women only:				
Endometriosis, ovarian cysts or tumors, breast lumps, or uterine fibroids				
Irregular, scanty, or suppressed menses.				
Clotting in menses flow.				
Dark menses flow at beginning.				
Light colored menses flow.				
Very heavy flow.				
Severe cramps: When, how long do				

they last? _____ _____.				
Premenstrual PMS grouchiness <input type="checkbox"/> , depression <input type="checkbox"/> , insomnia <input type="checkbox"/> , headaches <input type="checkbox"/> , bloating <input type="checkbox"/> , anger <input type="checkbox"/> , or nausea <input type="checkbox"/> .				
Nausea or migraines during menses				
Menopausal pains or difficulties. Hot flashes. ____ Night sweats. _____				
Vaginal dryness				
Infertility or lack of libido.				
men only:				
Painful or premature ejaculation.				
Prostate problems.				
Urination: frequent, dribbling, etc.				
Lack of interest in sex.				

Diet: Please briefly describe what you typically eat for your meals and snacks:

Breakfast:

Lunch:

Dinner:

Snacks:

Have you ever kept a food awareness journal? If so when and for how long? Were there any particular results that you remember from that?

How much coffee, tea or cola do you drink per day (ounces)? _____

How much water do you drink per day (ounces)? _____

Do you tend to be thirsty? _____

How much alcohol do you drink per week? _____

How much sugar do you eat each day (in what form)? _____

Emotional: Anger, fear, worry, sadness and grief, depression. Express emotions? How are your relationships with family and friends?

(Write on the back if the need exists)

