Holli K. Clepper
C.H.E.K Practitioner Level 3

Client History Form

Name:_____ Sex:____ Date of Birth_____

Address:_____ State:____ Zip:_____

Phone: hm_____ wk_____

E-mail:_____

Occupation:_____

School or Hours worked/week:_____

Do you travel for school? sports? work?_____If yes, how often?_____

Fitness Goal(s):_____

Date of last physical:_____

Are you currently under a physician's care?_____
If yes, what for?_____

Physician's Name:_____Phone number:_____

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Please complete all of the following, use the back-side if you need additional space.

If you answer yes to any of these questions, please explain

Have you ever experienced?

High Blood Pressure	YES	NO	_____
Heart Trouble	YES	NO	_____
Circulation Trouble	YES	NO	_____
Seizures	YES	NO	_____
Dizzy Spells	YES	NO	_____
Diabetes	YES	NO	_____

Other Illness YES NO

_____

Have you ever had surgery? YES NO

If yes, please list date, type of procedure, and outcome

Type of Surgery_____Date_____Outcome_____

Type of Surgery_____Date_____Outcome_____

Do you have any metal anywhere in your body (other than teeth)? YES NO

Do you have a cardiac (heart) condition? YES NO

_____

Do you have any trouble with vision? YES NO

Do you have any trouble with hearing? YES NO

_____

Are you pregnant? YES NO

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Do you have any allergies? YES NO
Please list: _____

List any medications you are currently taking: _____
_____

Have you ever had any physical therapy treatment? YES NO
If yes please explain: _____

Present injury:_____

_____

_____

Date of injury:_____

Have you ever seen a chiropractor? YES NO
If yes, please explain:

_____

_____

Do you smoke?_____If yes, how much per week?:_____

Do you drink alchohol?_____If yes how much per week?_____

I understand that payment is expected at completion of each session.

Name: Print_____

Signature_____ Date:_____

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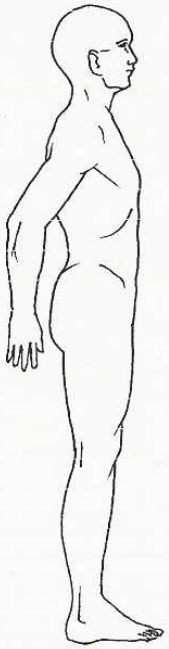
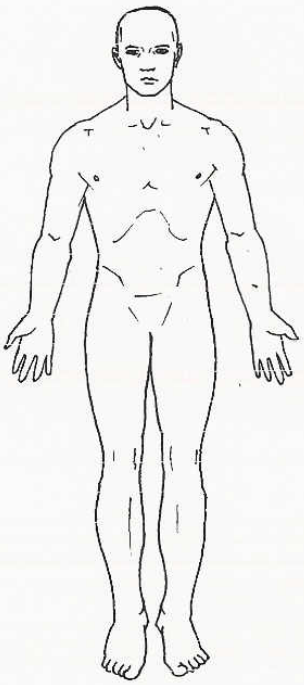
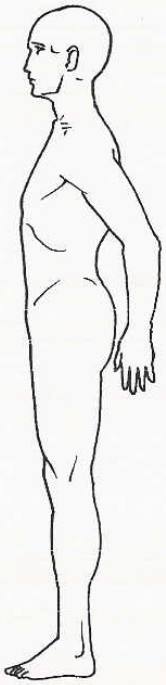
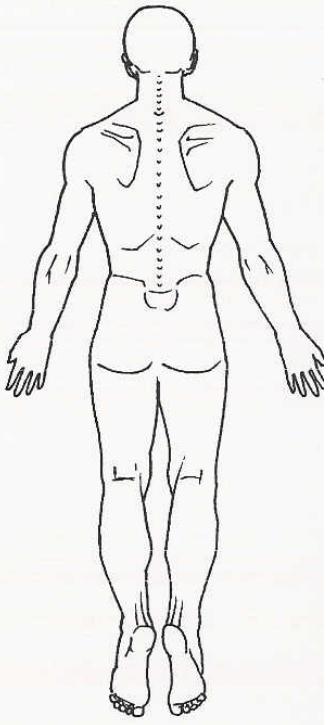
Symptom Record





Notes





Notes

Please indicate all areas you feel the following symptoms with the respective symbol:
Pain = Shaded Numbness = X Tingling = Dots Swelling = O Spasm = #

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HISTORY OF SYMPTOMS

How long have symptoms been present?

_____

_____

_

Improving / Unchanging / Worsening?

Commences as a result of:

_____

_____

_

Symptoms: Constant or Intermittent

Worse when:

- ☐ **sitting**
- ☐ **turning**
- ☐ **lying/rising**
- ☐ **am / as day progresses / pm**
- ☐ **stationary / on the move**

Better when:

- ☐ **sitting**
- ☐ **turning**
- ☐ **lying/rising**
- ☐ **am / as day progresses / pm**
- ☐ **stationary / on the move**

Do symptoms disturb your sleep?

_____

_____

_

In which position do you sleep in? back / side / belly

Does it hurt to cough, sneeze, or swallow?

_____

_____

_

Previous Treatment? _____

_____

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Medications:_____
_

Any significant weight loss recently:
_____

Recent Surgeries that could be causing the pain?:
_____
_

Accidents that could be causing the pain?:_____

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