Optimum Energy & Wellness®

Client Health History Confidential Information

(Please fill out this form and bring it with you to your first session.)

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Mobile: _____ Email: _____

Date of Birth: _____ Age: _____

Referred by: _____

Have you ever experienced any type of energy work or bodywork? Yes ☐ No ☐

Type of bodywork experienced: _____

Health History

Medications: _____

Surgeries: _____

Accidents: _____

Sleep Pattern: _____

Digestion (assimilation): _____

Respiratory: _____

Circulatory: _____

Urogential/Reproductive: _____

Endocrine: _____

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Health History (continued)

Nervous System: _____

Elimination: _____

Other problems or conditions: _____

_____

_____

Energy Level: _____

Check if you have any of the following:

__ Accident
__ Neck Pain
__ Whiplash
__ Headaches
__ Disk Problems
__ Mid/Low Back Pain
__ High Blood Pressure
__ Joint Ache
__ Decreased Range of Motion
__ Broken Bones
__ Sprains
__ Abdominal Pain
__ Nervous Tension
__ Arthritis, Bursitis, Gout
__ Allergies to Oils or Perfumes
__ Wear Contacts or Other Prosthesis
__ Surgery
__ Fibromyalgia
__ Breast Augmentation
__ Diabetes
__ Varicose Veins
__ Stroke
__ Heart Attack
__ Cancer
__ Colitis
__ HIV

Please Indicate Your Consumption:

	None	Light	Moderate	Heavy
Salt	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Water	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Please indicate with an (X) where you have discomfort.