Client Health Record

Holistic Health of Long Island
holistichealthofli@gmail.com
631-260-6332
www.holistichealthofli.com

Personal Information

Date:_____

Name: _____ Address: _____

Phone# _____ City, State, Zip:_____

Date of Birth:_____

Referred By: _____ Internet ___ Flyer ___ Other _____

Present Major Concern/Complaint:

_____

_____

Current Symptoms: _____

_____

Has there been a medical diagnosis: ___ Yes ___ No

If so, by whom? _____ Rx(s) Prescribed:_____

Please explain: _____

_____

When did you first notice symptoms/complaints:_____

What brought it on:_____

Is the condition getting worse: ___ Yes ___ No

List other therapies you receive: _____

Does this condition interfere with: Work___ Sleep___ Daily Routine ___ Sex Life ___

Please explain:_____

What have you tried using to get relief? _____

What activities aggravate the condition? _____

What activities or products improve the condition?_____

Describe the exercise activities you do and how often?_____

_____

_____

Any allergies (food, drugs, airborne)? _____

_____

_____

_____

_____

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What are your long-term health care goals? _____

_____

_____

Current medications, including vitamins/supplements you are taking:

_____

_____

_____

_____

Please list any additional comments or concerns regarding your health and well-being:

_____

_____

_____

_____

Please make sure you fill out the Informed Consent Form and email both to: holistichealthofli@gmail.com
Thank you!