CLIENT HISTORY

Full name: Date:

Address: Suburb:

City: Postcode: Age: DOB:

Phone (H): (W): (M):

email: Referred by:

Family GP: Other health professional:

Occupation: How long in this work:

Past occupations:

Siblings:

Spouse/Partner name:

Children:

Past trauma/accidents:

Past surgery:

Childhood and other illnesses:

Current medication:

Current supplements:

Food preferences: ☐ 'meat +3 veg' ☐ vegetarian ☐ vegan ☐ macrobiotic ☐ high protein

☐ wheat free ☐ gluten free ☐ dairy free ☐ other:

Daily intake: sugar: coffee: tea: alcohol: water:

Interests/socialising/clubs: sports:

Exercise:

Social History/Self development:

Name: Date:

CLIENT HISTORY

History (reasons why you are here)

Current problem list:

History of development of symptoms:
Duration:
Timing (continuous /intermittant):
Model of onset (sudden, gradual, series of attacks):
Symptom modification:

What makes it better?

What makes it worse?

Associated features:

Modification of symtoms:

What the Dr. said:

Is there anything else I should know?

Name: Date:

CLIENT HISTORY

A. ☐ Cardiovascular System
   a. ☐ Dyspnea:
      i. ☐ When does it come on; rest or only exertion?
      ii. ☐ Attacks at night?
      iii. ☐ Can client lie down, or needs to have pillows or sitting up in bed to avoid breathlessness?
      iv. ☐ Any pain or associated distress?
      v. ☐ What precipitates or relieves it?
   b. ☐ Palpitation:
      i. ☐ What brings it on?
      ii. ☐ How long does it last?
      iii. ☐ What is pulse like in an attack – regular or irregular?
   c. ☐ Lower Limbs:
      i. ☐ Pain
      ii. ☐ Coldness
      iii. ☐ Pallor
      iv. ☐ Cyanosis
   d. ☐ Edema:
      i. ☐ Where
      ii. ☐ When
   e. ☐ Pain:
      i. ☐ Where
      ii. ☐ When
      iii. ☐ Radiation
      iv. ☐ Relieving factors
      v. ☐ Precipitating factors
      vi. ☐ Aggravating factors
      vii. ☐ Quality of pain

B. ☐ Respiratory System
   a. ☐ Ask about:
      i. ☐ Smoking
      ii. ☐ Allergies
      iii. ☐ Occupation
      iv. ☐ Exposure to animals or birds
      v. ☐ Mineral or vegetable dust
      vi. ☐ TB (tuberculosis)
   b. ☐ Cough:
      i. ☐ Dry or productive
      ii. ☐ Painful or not?
      iii. ☐ Worse at any one time of day or night?
      iv. ☐ Worse by any particular conditions eg. dust, cold, pollen?

Name: Date:

CLIENT HISTORY

c. ☐ Sputum:
   i. ☐ Quantity
   ii. ☐ When in day most produced?
   iii. ☐ Consistency
   iv. ☐ Colour, odour, purulent?
   v. ☐ Blood streaks or clots?
   vi. ☐ How often?

d. ☐ Dyspnea:
   i. ☐ When does it occur?
   ii. ☐ Constant or intermittent?
   iii. ☐ What sort of activity produces it?
   iv. ☐ Anything provoke it?

e. ☐ Wheeze:
   i. ☐ When does it occur?
   ii. ☐ Constant or intermittent?
   iii. ☐ Anything provoke it?
   iv. ☐ Worse in day or night?

f. ☐ Chest Pain:
   i. ☐ Where is it?
   ii. ☐ Aggravated by deep breathing or coughing
   ie. Pleuritic?
   iii. ☐ Associated with increased cough
   or sputum or dyspnea?
   iv. ☐ Rate of onset?

C. ☐ Nervous System:

a. ☐ Ask about:
   i. ☐ Family history of:
   ☐ mental illness
   ☐ paralysis
   ☐ fits
   ii. ☐ Nature of work eg. Exposure to poisons eg.
   Pb, Mn, Hg, syphilis, alcohol, tropical infections?
   iii. ☐ Headaches
   iv. ☐ Weakness or paralysis
   v. ☐ Parasthesia
   vi. ☐ Sensory Loss
   vii. ☐ Speech disturbances
   viii. ☐ Fits, faints, or funny turns
   ix. ☐ Comprehension disorders
   x. ☐ Abnormal movements
   xi. ☐ Memory loss
   xii. ☐ Personality changes
   xiii. ☐ Vertigo

Name: Date:

CLIENT HISTORY

D. ☐ GIT, Abdomen and Pelvis

1. ☐ Upper Gastro-intestinal Tract
   a. ☐ Pain:
      i. ☐ pain vs discomfort or fullness?
      ii. ☐ Site and severity – local or diffuse –
      length of time?
      iii. ☐ Radiation?
      iv. ☐ Relation to meals?
      v. Wake at night?
      vi. ☐ Aggravating and relieving factors
      (eg. Food, antacids, vomiting)?
   b. ☐ Appetite:
      i. ☐ Increased or decreased?
      If decreased is it because of
      no hunger or afraid of pain?
      ii. ☐ Anorexia?
   c. ☐ Weight:
   Increased or decreased or stationary?
   d. ☐ Vomiting (emesis):
      i. ☐ Frequency, relation to pain?
      (does it relieve pain or not?)
      ii. ☐ Amount and colour?
      iii. ☐ Any blood, coffee grounds, old food?
      iv. ☐ Distinguish between vomiting and regurgitation?
   e. ☐ Flatulence/Flatus:
      i. ☐ Up (flatulence) does it relieve the symptoms?
      ii. ☐ Down (flatus) does it relieve the symptoms?
   f. ☐ Heartburn:
      i. ☐ Pain behind sternum? Is it worse on lying?
   g. ☐ Dysphagia:
      i. ☐ Difficulty swallowing, if so where
      does food stick?
      ii. ☐ Worse with solids or liquids?

2. ☐ Lower Gastro-intestinal Tract

☐ Change in bowel habits.

   a. ☐ Diarrhoea:
      i. ☐ Number of times, when in relation to meals?
      ii. ☐ Colour, formed, unformed, frothy, watery?
      iii. ☐ Float and difficult to flush?
      iv. ☐ Any blood or slime or undigested foods?
      v. ☐ Pain during defecations?
      vi. ☐ Laxatives, purgatives or anything else to
      give loose motions?

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CLIENT HISTORY

b. ☐ Constipation:
   i. ☐ Usual bowel habit, any recent change?
   ii. ☐ If change, can it be explained by diet or treatment?
   iii. ☐ Alternate constipation/diarrhoea?
   iv. ☐ Colicky pain?
   v. ☐ Blood – is it on surface or mixed in with stool?
   vi. ☐ Vomiting?
   vii. ☐ Are they using opiates or codeine?

c. ☐ Pain:
   i. ☐ Site
   ii. ☐ Radiation
   iii. ☐ Character
   iv. ☐ Where felt worse
   v. ☐ Persistent or intermittent
   vi. ☐ Relieved by defecation or flatus?

3. ☐ Liver and Gallbladder:

a. ☐ Jaundice:
   i. ☐ Any change in colour of urine and faeces?
   ii. ☐ Itchy skin?
   iii. ☐ Jaundice in family, friends, workmates?
   iv. ☐ verseas travel?
   v. ☐ Injections in the last 3 - 6 months?
   vi. ☐ Use of drugs?

b. ☐ Pain:
   i. ☐ Site, quality, colicky, radiation?
   ii. ☐ Was he/she jaundiced after it settled?
   iii. ☐ Intolerance to fatty food?
   iv. ☐ Belching?

E. ☐ Genito-Urinary Systems:

1. ☐ Genital System

a. ☐ Structural
   i. ☐ Discharge
   ii. ☐ Swelling of testes,
   iii. ☐ Ulcers on genitals
   iv. ☐ Gynaecological abnormalities (females)

b. ☐ Functional disorder.
   i. ☐ Coital difficulties - pain, irritation
   ii. ☐ Impotence
   iii. ☐ Other worries about sexual dysfunction.

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CLIENT HISTORY

2.☐ Urinary System

a. ☐ Ask about:

i. ☐ Tonsillitis or previous renal disease?

ii. ☐ Family history of renal disease or hypertension?

iii. ☐ Analgesic intake?

iv. ☐ Pain in lumber region?

v. ☐ Shooting to groin or testicles?

vi. ☐ Pain in suprapubic region?

vii. ☐ Face puffy in the morning?

viii. ☐ Swollen ankles?

ix. ☐ Pain in micturition?

b. ☐ Urine:

i. ☐ Amount, has it altered,
has it increased at night?

ii. ☐ Colour change, clear or turbid when passed?

iii. ☐ Frequency – by day?
eg. in cystitis

iv. ☐ Frequency by night?
eg. in Benign Prostatic Hypertrophy

v. ☐ Blood – at beginning or end?

vi. ☐ Is there increased thirst?

vii. ☐ Polyuria - distinguish between
diabetes and chronic renal failure?

F. ☐ Locomotor System:

a. ☐ Arthralgia - joint pain

i. ☐ Bone or joint pain:

ii. Joint swollen:

☐ Is it one joint or many?

☐ Does it change from one joint to another?

b. ☐ Myalgia - muscle pain

i. ☐ constant, intermittant, fleeting

ii. ☐ any flickering or twitching

c. ☐ Limited movement

d. ☐ Joint swelling

If symptoms relate to bone or joint:

i. ☐ Any history of: rheumatic fever,
gout or rheumatoid arthritis

ii. ☐ Associated skin condition
eg. Psoriasis

iii. ☐ Any associated bowl condition
eg. Crohns, Irritable colon, Ulcerative colitis

iv. ☐ Associated eye condition
eg. Conjunctivitis, iritis

v. ☐ Urethral or vaginal discharge, gonorrhoea,
STD or syphilis

Name: Date:

CLIENT HISTORY

G. ☐ Skin

a. Ask about:

i. ☐ Duration, distribution of lesions

ii. ☐ Personal habits with:
diet, washing, clothing

iii. ☐ Any drug intake medications,
herbs, vitamins (synthetic)

iv. ☐ Is it itchy, when is it worse?

v. ☐ Any allergic conditions eg. Asthma, hay fever

vi. Any contact with:

☐ animals

☐ insects

☐ pollen