Veritas Wellness
True healing for the whole body and mind

# Client History Form

| | |
|---|---|
| Name: | Email: |
| Address: | City, State, Zip: |
| Home Phone: | Other Phone: |
| Cellular Phone: | Referred by: |
| Date: | Date of Birth: |

## Part 1.General Health

Describe the problem(s) for which you seek help.

_____
_____
_____
_____

Describe past medical history (previous injuries, accidents, surgeries, illnesses, etc.). Include approximate dates.

_____
_____
_____
_____

Have you ever been the victim of abuse or neglect?

_____
_____
_____

Please list and describe any stresses in your life.

_____
_____
_____
_____

| Please circle the level of stress. | | | | |
|---|---|---|---|---|
| My family stress is: | None | Minimal | Moderate | Severe |
| My relationship stress is: | None | Minimal | Moderate | Severe |
| My work stress is: | None | Minimal | Moderate | Severe |
| My financial stress is: | None | Minimal | Moderate | Severe |
| My health stress is: | None | Minimal | Moderate | Severe |
| Other stress is: | None | Minimal | Moderate | Severe |

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc.?

_____
_____

How many hours a night do you sleep? _____
Is your sleep restful? _____
If not, please explain: _____

## Part 2.Family & Childhood

If additional space is needed, use back or attach an additional sheet.

In a few sentences, describe your relationship with your mother during your childhood (from your perspective).

_____
_____
_____
_____

In a few sentences, describe your relationship with your father during your childhood (from your perspective).

_____
_____
_____
_____

In a few sentences, describe what it was like to grow up in your family.

_____
_____
_____
_____

List any significant traumas from your past (premature birth, car accidents, divorce, abuse, mental illness, etc.):

_____
_____
_____
_____

## Part 3.Recent Emotions

| Please check any of the following feelings you have experienced in the last few months. | | | |
|---|---|---|---|
| ☐ Abused | ☐ Paranoid | ☐ Unable to grieve | ☐ Panic |
| ☐ Criticized | ☐ Overwhelmed | ☐ Apprehensive | ☐ Intolerant |
| ☐ Overworked | ☐ Muddled | ☐ Agitated | ☐ Uncertainty |
| ☐ Paralyzed | ☐ Persecuted | ☐ Uneasy | ☐ Aggravated |
| ☐ Depressed | ☐ Guilty | ☐ Distress | ☐ Annoyed |
| ☐ Rejected | ☐ Easily irritated | ☐ Fearful | ☐ Angry |
| ☐ Despair | ☐ Anxious | ☐ Impatient | ☐ Outraged |
| ☐ Helpless | ☐ Sad | ☐ Intimidated | ☐ Nervous |
| ☐ Hopeless | ☐ Grieving | ☐ Restless | ☐ Worried |

## Part 3. Pain

Please list any areas of pain or discomfort in the body. Rate each area according to the scale below and list details, if necessary.

Rating:
1. Slightly aware of discomfort
2-3. Aware of discomfort as an aggravation
4-6. Pain is strong but you are still functional
7-9. Pain is so strong you are unable to function normally
10. You feel like you need to go to emergency room

Areas of pain and discomfort:

_____
_____
_____
_____
_____

Date form completed: _____
Person completing form: _____