

Adagio Holistic Therapies, LLC.
Phone: 612-288-0488

Personal Information

Name _____ Date of First Visit _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Occupation _____
Date of Birth _____ Sex M or F Emergency Contact _____ Phone (Day) _____ (Eve) _____
Marital Status _____ If not married, do you have a significant other _____ Do you have children _____ ages _____
How did you hear about Adagio Holistic Therapies? _____

Background Information

Have you had massage therapy or bodywork before? _____ Where and What Type? _____
How long ago? _____ Frequency? _____
Do you exercise regularly or participate in sports? _____ What? _____ How Often? _____
Do you stretch? _____ X per week? _____
What is your current stress level? (low) 1 2 3 4 5 (high) Is the stress positive or negative or both? _____

Specific Complaints

What is your major area of pain or concern? _____
When did you first notice it? _____ What brought it on? _____
What activities aggravate it? _____
At or around the time of the onset were there other emotional stresses occurring? _____
Is this condition getting worse? _____ Does it interfere with work? _____ sleep _____ recreation _____
What do you believe is wrong with you? _____
What have you done to get relief? _____
Have you sought a diagnosis? _____ By whom? _____ Diagnosis _____
Other areas of pain or concern _____

Stress level

How many hours of sleep do you get in an average night? _____
Do you usually wake feeling rested? _____ Tired? _____ Other? _____ Nerves (circle one) Good Fair Poor
Anxiousness: Often Sometimes Seldom Explain _____
Depression: Often Sometimes Seldom Explain _____

Digestion and Diet

Typical Breakfast _____
Typical Lunch _____
Typical Dinner _____
Snacks _____
How many meals per week do you order or dine out? _____

How many times a week do you have:

Beef _____	White Rice _____	White Bread _____	Soda pop _____
Pork _____	Chicken _____	Fish _____	Ice cream _____
Desserts _____	Milk _____	Candy _____	Other dairy _____
Chips _____	Canned food _____	Crackers _____	Pretzels _____

Do you add salt to your food _____ What would you say is the worst thing you do on your diet? _____

Indicate the following habits with **H** - heavy **M** - moderate **L** - light **N** - None

_____ Alcohol _____ Coffee _____ Tea _____ Colas _____ Tobacco _____ Marijuana _____ Other

of glasses of water per day _____

Are you subject to binge eating? _____ On what foods? _____

What food do you find to be your weakness? _____

Appetite (circle one) Good Fair Poor Explain _____

Digestion Good Fair Poor Explain _____

Do you experience bloating or gas after meals? _____ Do you have sour burps? _____ Heartburn? _____

Do you feel sleepy or tired after meals? _____ If so, how often? Daily Weekly Occasionally

Are you on a restricted diet? _____ Please explain _____

How often do you have a bowel movement? Daily _____ _____ times per week Irregular _____

Do your stools sink or float? (circle one)

Have you ever had hard stools? _____ If so, how often _____ Loose stools? _____ If so, how often? _____

Urination (circle as applicable) Normal Scanty More than 5 times daily Burning Strong odor Dark color

Any history of bladder or kidney infections? _____ if so, age _____

Family History

Alive? Age /Cause of death Major ailments while alive

Maternal Grandmother _____

Maternal Grandfather _____

Paternal Grandmother _____

Paternal Grandfather _____

Father _____

Mother _____

(optional) Is there a history of abuse in your family? _____ (circle one) emotional physical sexual spiritual

Is there a history of drug or alcohol abuse in your family? _____

Is there a history of suicide in your family? _____

Emotional and Spiritual

If romantically involved, how is your relationship _____

Were there any emotional traumas in your early or present life? (i.e. rape, great loss, suicide, death of a loved one etc.) _____

If possible please explain the negative emotion you experience most _____

When do you most often feel this emotion _____ Where are you when you feel this emotion _____

What is your opinion of yourself _____

Have you ever been to counseling _____ What was the outcome for you _____

Do you pray to a higher power _____ How often _____ Do you meditate _____ How often _____

Rate yourself: None Some Lots

Faith _____

Hope _____

Charity _____

Generosity _____

Sense of humor _____

Sense of fun _____

Is there an unrealized longing in your life _____ If so, what is it _____

Are you involved in activities outside of work _____ if so, what type _____

Hobbies or interests _____

Is your love life satisfying _____

Birth and Early Childhood

My birth was: (circle one) Normal Difficult Unknown

Please explain _____

Briefly explain your *early* relationship with each of your parents _____

Briefly explain your *present* relationship with each of your parents _____

Medical History

Are you currently under the care of a doctor, chiropractor or other health care practitioner? _____

If so, for what condition? _____

Name of Practitioner _____ City _____ State _____ Phone _____

List any medications you are taking _____

For how long _____ Do you have allergies (if so, to what) _____

Previous broken bones including year _____

Previous accidents including year _____

Previous surgeries including year _____

Other hospitalizations including year _____

Childhood accidents or physical traumas _____

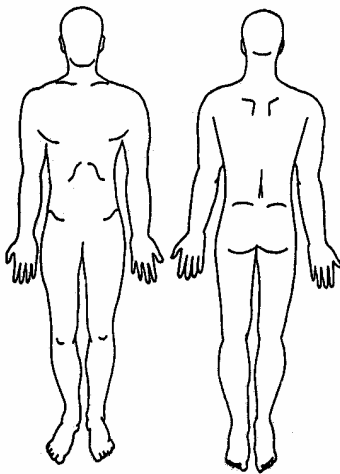
List any medications you took as a child and how long taken _____

Have you ever hit or fallen on your head or tailbone? _____ Did you suffer trauma at birth? _____

Circle any of the following you are *CURRENTLY* experiencing: Underline any you have had as a *PAST* problem.

- | | | | |
|-----------------------|---------------------------------|--|--|
| Headaches | Ringings in ears | Pins and needles in arms & hands | Pins and needles in legs |
| Shooting pain in head | Asthma | Cold hands | Swollen ankles |
| Sinus trouble | Epilepsy or other seizures | Heart pain | Cold feet |
| Loss of smell | Muscle spasms in neck | Blood clots, phlebitis | Pains in legs and feet |
| Loss of taste | Grating in neck | Skin disorders, acne, fungus, rash | Sciatica |
| Tightness in throat | Tightness in shoulder muscles | Painful joints | Numb hands or feet |
| Face flushed | Painful menstruation - cramps | Swollen joints | Constipation |
| Loss of memory | Contact lenses or dentures | Pins and needles in back | Allergies |
| Fatigue | Sensitivity to oils and lotions | Herniated or bulging disk | High or low blood pressure |
| Depression | Lung or breathing problems | Pinched nerve in back | Spinal problems |
| Head feels too heavy | Pregnancy | Arthritis, osteoporosis, brittle bones | Varicose veins or other circulatory problems |
| Diabetes | Fainting Spells | Hepatitis | Emotional problems |
| Frequent flu or cold | Anorexia/Bulimia | Cancer | Bad Breath |
| Heart problems | Kidney problems | | |

Mark any areas of current, persistent or chronic tension/pain on the figures below:



Please read and sign.

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I agree to give at least 24 hours notice of cancellation of appointment. Cases of extreme emergency are considered exceptions to this cancellation policy.

I understand the treatment here is not a replacement for medical care. I understand the therapist does not diagnose medical illness, disease, or any other physical or mental condition. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. I understand that the treatment is not a substitute of medical treatments and/or diagnosis and that it is recommended that I see a qualified professional for any physical or mental conditions that I may have. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my health.

Client Signature _____ Date _____

Therapist _____