Personal History (Confidential)

for the office of Kalyani Gilliam, L.Ac. /Rolfer/Feldenkrais/Morphogenic Field Testing

Name____ Phone____

Address_____________________________________ Cell ____

____ Email____

Birthdate___________________________________

Referred by_________________________________ Occupation____________________________________

Today's date____________________

Main Reason(s) for seeking care here?

What would you like to receive from our time together? (Expectations)

Medical History:

Congenital history

Broken bones? Sprains?

Surgeries? (type, year of)

Known significant body injuries

Known malignancy

Do you wear: Glasses, contacts? Yes No Lifts, arch supports? Yes No

Please describe your:

Appetite/Digestion?

Respiration?

Circulation? / Body temperature?

Sleep?

Energy?

Mood?

Women:

Reproductive history (pregnancies, abortions, miscarriages, births)

Do you use birth control now or ever in the past? What kind? For how long?

Do you experience problems during your cycle (describe)?

Treatment History:

What treatments have you utsed to deal with your current situation? (What helps; what makes it worse?)

List any practitioners/treatments that you like to use to maintain your health?

Drugs, Diet, Nutrition- Describe your relationship with:

Sugar
Alcohol
Caffeine
Tobacco
Vitamin/supplements

Prescription meds

Non-prescription drugs

Are you on any special diet?

Activity Profile: List activities you are restricted from doing:

What is your current exercise routine?

What brings you joy?

Anything else you would like me to know?