Client History Questionnaire

Qigong is a holistic system of healing and care based in the wisdom of ancient Chinese medicine and science. Consideration of environmental influences surrounding the body, as well as internal occurrences, contributes greatly to effectiveness of treatment and self-practice instruction. We thank you for taking the time to provide us this important information about yourself.

Name___________________________________ Today's Date __________________
Birth Date _____________ Age ______ Weight__________ Height__________

My Main Reason for Treatment ____
____

Domestic/Living Situation (own/rent, partner, children, pets, caregiving, etc.) _______________________
____

Lifestyle
Work: Shift begins _____AM/PM Shift ends _____AM/PM
Recreation/Frequency: ____
____
Community: ____
____
Caffeine: Coffee _____cups/day Tea _____cups/day Soda _____cans/day
Alcohol:________________________/day Cigarettes/cigars:_____/day

Sleeping Pattern
Usual bedtime _______AM/PM Usual wake time _______AM/PM
Number of awakenings _________ Naps per week ____________

Please check all that apply to you:

___ Fall asleep initially without difficulty
___ Fall asleep inappropriately
___ Don't feel tired at bedtime
___ Have difficulty going back to sleep
___ Indigestion/heartburn while asleep
___ Loud and disruptive snoring
___ Snoring is worse on back
___ Stop breathing during sleep
___ Restless sensation in legs
___ Leg jerks during sleep
___ Kicking or twitching during sleep
___ Grind teeth in sleep
___ Sleep talk
___ Sleep walk
___ Bed partner disturbs sleep
___ Feel refreshed after naps
___ Awaken long before it is necessary
___ Difficulty waking in the morning
___ Feel refreshed on awakening
___ Feel groggy/foggy on awakening
___ Feel tired and fatigued while awake
___ Sore throat on awakening
___ Have headaches on awakening
___ Wake up gasping for air
___ Awaken and feel paralyzed
___ Muscle stiffness when first awake
___ Joint pain when first awake
___ Jaw aches in the morning
___ Sudden awakening w/ intense emotion
___ Other: _________________________________

Medical History. Please check all that apply to you:

___ Hypertension	___ Mitral Valve Prolapse	___ Other Heart Issue: __________
___ Chest Pain	___ Chronic Cough	___ Sputum with Cough
___ Lung Illness	___ Short of Breath	___ Asthma/Respiratory Issue
___ Digestion Issue	___ Hiatus Hernia	___ Other GI Issue: ____________
___ Cancer	___ Anemia/Blood Disorder	___ Auto-immune Issue
___ Cognitive Issue	___ Seizures	___ Neurological Problems
___ Anxiety	___ Depression	___ Swelling of Feet
___ Menstrual Issue	___ Libido Issue	___ Over/Under Weight

___ Other: ____

Surgeries:____

Environmental Allergies:____

Chemical Allergies: ____

Food Allergies: ____

Medication Allergies:____

Medications/Supplements

Name Dosage Times Taken

____

____

____

____

Family History (ethnicity, parentage, brothers, sisters, their ages, etc.)

____

____

____

Experience in Managing Stress (relaxation/meditation techniques, exercise, gardening, quiet time/space, etc.)

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Please complete prior to, and return this form at your next visit. Feel free to contact Jeff with any questions that come up.

JEFF SMITH

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