ROB + KATIE TRUAX

LIVE YOUR BEST LIFE

Client History and Information

Thank you for choosing to work with Dr. Robert Truax, DC and Katie Truax, LMHC. Please answer the questions below as honestly and completely as possible so that we will know how to best support you on your journey toward living your best life.

Client Name:_____ DOB: ____/____/____ Age: _____

❑ Male ❑ Female Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Separated

Address: _____

Primary Telephone Contact:_____ Email Address: _____

Local Emergency Contact: _____ Telephone: _____ Relation: _____

How did you hear about us? Please be as specific as possible. _____

❑ Check here to opt out of receiving notification via email of upcoming events, workshops, and discounts.

Primary complaints: _____

_____

Height: ___ ft. ___ in Current Weight: _____ lb Ideal Weight: _____ lb

Would you like help losing or gaining weight? ❑ Yes ❑ No

Are you currently under the care of any other physician or health care professional? ❑ Yes ❑ No

If yes, Doctor's name: _____ Specialty:_____

Reason for care: _____ Date of last visit:_____

Significant Health History: _____

_____

Current Medications/Supplements: _____

_____

Symptom Profile: PLEASE DESCRIBE EACH SYMPTOM ENDORSED

Suicidality: Y/N If so, please indicate: Thoughts: **Y/N** Plan: **Y/N** Intent: **Y/N** Hist. of attempts: **Y/N**

Loss of Interest _____Hopelessness _____

Grief/Loss _____ Depressed Mood _____

Fatigue/Low Energy _____ Difficulty Concentrating _____

Recent change in appetite _____Weight Related Issues _____

Sleep Difficulties _____ Sexual Issues _____

Self-harm _____ Mood Swings _____

Expansive/Elevated Mood _____ Menstrual Difficulties _____

Risky Behavior _____ Irritability _____

Anger _____ Impulsiveness _____

Desire to harm others: _____ Fertility Challenges: _____

Anxiety/Worry _____ Racing Thoughts _____

Neck stiffness/pain _____ Back stiffness/pain _____

Pain elsewhere in the body _____ Relationship Difficulties _____

Difficulty falling asleep_____ Difficulty staying asleep _____

Tired upon awakening _____ Nightmares _____

Digestive difficulties _____ Hallucinations _____

Allergies/Sinus Problems _____ Headaches _____

Memory Challenges _____ Spacing out/Blacking out _____

Loss of Time _____ Dissociation _____

Flashbacks _____ Startle Easily _____

Emotionally Numb _____ Panic _____

Substance Abuse _____ Challenges with Food/Eating _____

Trauma History _____ Other _____

_____

_____