

Lydian Center

Comprehensive Brain Integration

Client Medical History

Name:		Date:	
Address:			
		Postcode:	
Telephone:	(H)		(W)
Date of Birth:		Age:	
Marital Status:	Married	Single	Divorced
			Separated
			Widow(er)
Do you have children?		If yes, how many?	
Occupation:		Previous:	
Hobbies/Interests:			
Referred by:			
Briefly describe the health problem(s) you would like to resolve:			
How long have you had the problem?			
Do you regard your health problem(s) to be:	Severe	Quite Severe	Moderate
			Mild
What other forms of therapy have you used to resolve your health problem(s)?			
Diet		Allopathy	Acupuncture
Physiotherapy		Vitamins/Minerals	Herbs
Chiropractic		Other (please state)	
How successful were they?	<i>Very successful</i>		<i>Quite successful</i>
	<i>Slightly successful</i>		<i>Not Successful</i>
Do you have any specific illness or problems recurring from time to time - (ie. rashes, premenstrual pain, sleeplessness, insomnia, shortness of breath, migraines, constipation, dyspepsia, cystitis, incontinence, infections, coughs, colds..... etc)?			
Do you have any ongoing disease(s) - (ie. asthma, hypertension, diabetes, arthritis, cancer, coronary heart disease, ulcers...etc.)?			

Please list previous/other: illness/accidents/surgery that you have had and the year in which it occurred:

Do you take any of the following:

Herbs	<input type="checkbox"/>	Vitamins	<input type="checkbox"/>	Homeopathics	<input type="checkbox"/>
Flower Essences	<input type="checkbox"/>	Minerals	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	Food Additives	<input type="checkbox"/>	Medication/Drugs	<input type="checkbox"/>
Amino Acids	<input type="checkbox"/>	Anti-oxidants	<input type="checkbox"/>	Birth control pill/HRT	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	Antacids	<input type="checkbox"/>	Tinned or processed foods (regular basis)	<input type="checkbox"/>

Do you have any allergies? If yes, please state:

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What is your daily water intake? (not including fruit juice, soft drinks, tea, coffee, alcohol).

2 Litres	<input type="checkbox"/>	1 Litre	<input type="checkbox"/>	500ml	<input type="checkbox"/>	less	<input type="checkbox"/>
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Briefly describe your diet:

Breakfast	
Lunch	
Dinner	
Snacks	

What are your favourite foods?

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Are your bowel movements: daily less than daily

How often do you exercise?

<input type="checkbox"/> daily	<input type="checkbox"/>	<input type="checkbox"/> weekly	<input type="checkbox"/>	<input type="checkbox"/> occasionally	<input type="checkbox"/>	<input type="checkbox"/> never	<input type="checkbox"/>
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On a scale of 1-10 what is your daily energy level?

Are there any problems/stress factors in your life at the moment?

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My stress levels at the moment are: High Quite High Middling Low

My living situation is:

<input type="checkbox"/> very good	<input type="checkbox"/>	<input type="checkbox"/> good	<input type="checkbox"/>	<input type="checkbox"/> not good	<input type="checkbox"/>	<input type="checkbox"/> poor	<input type="checkbox"/>
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My working situation is:

<input type="checkbox"/> very good	<input type="checkbox"/>	<input type="checkbox"/> good	<input type="checkbox"/>	<input type="checkbox"/> not good	<input type="checkbox"/>	<input type="checkbox"/> poor	<input type="checkbox"/>
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<i>Relaxation/Meditation</i>		None		Occasionally		Often		Daily	
<i>Are you a</i>	Non smoker		Smoker		Tobacco		Other		
<i>Where you a smoker?</i>			<i>From when to when?</i>						
<i>Was your birth</i>			Normal		Induced		Caesarean		
<i>Do you use orthotic appliances in your shoes?</i>									
<i>Do you experience back or neck pain or other physical pain?</i>									
<i>Do you experience ringing in the ears, clicking/popping of the jaw or facial pain?</i>									
<i>If you are female: Are you pregnant?</i>				<i>If yes, how advanced?</i>					
Menstrual Cycle:									
Duration of Cycles (No. of days)				Duration of Menses (regularity)					
Regular		Irregular				Painful			
Heavy		Menopausal				Other			
<i>Please tick any of the following issues which relate to you and place two ticks against those you would like to deal with:</i>									
Nervousness		Depression		Fears		Shyness			
Sexual Problems		Suicidal thoughts		Separation		Divorce			
Finances		Drug Use		Alcohol Use		Friends			
Anger		Self control		Unhappiness		Sleep Apnoea			
Stress		Work		Relaxation		Headaches			
Tiredness		Legal matters		Memory		Ambition			
Energy		Insomnia		Loneliness		Education			
Concentration		Making decisions		Temper		Nightmares			
Career Choices		Inferiority		Marriage		Children			
PMS		Unpleasant Memories		Repetitive Thoughts		Parenting			
Pain		Enemies		Communication skills		Motivation			
Regrets		Anxiety		Dizziness		Grieving			
Guilt		Trust		Infertility		Back Pain			
Tinnitus		Joint Pain		Bed Wetting		Neck Pain			
<i>Is there anything else in your life that you would like to:</i>									
stop doing		start doing		do better		do differently			
Please briefly explain:									

Dr. Charles T. Krebs Appointment Cancellation Policy

Your appointment time is important. Missed appointments and late cancellations prevent other people who are in need from receiving timely treatment.

If you cannot keep your appointment for any reason, please call us 48 hours or more prior to your appointment time. If you do not show for your appointment or you cancel with less than 24 hours notice, **you will be charged 100% of the standard appointment fee.** If you do not show for your appointment or you cancel with less than 48 hours notice **you will be charged 50% of the standard appointment fee.** If you are late for an appointment, your visit may be shortened.

Thank you for helping us to keep appointments available for everyone!

I, _____ (print name), have read and understand Dr. Charles Krebs' Appointment Cancellation Policy and agree to honor it.

Signature of Client or Responsible Party if a Minor

Date

(If Client is a Minor, Print Name of the Client)