

BAREFOOT HEALTH CARE CLIENT INFORMATION

NAME _____ DATE _____ TIME _____

ADDRESS _____

_____ HOME

PROFESSION _____ PHONE _____

_____ BUSINESS

DATE OF BIRTH _____ MARITAL STATUS _____ CHILDREN _____ PHONE _____

MAJOR COMPLAINT _____ DATE INCURRED _____ ONSET _____

DESCRIPTION _____

ACUTE/CHRONIC PREVIOUS RX _____

PRESENT SYMPTOMS

PAIN YES\NO _____

WHERE _____

TYPE OF PAIN _____

(SHARP/DULL/BURNING) _____

NUMBNESS/PINS AND NEEDLES YES/NO _____

WHERE _____

MUSCLE WEAKNESS _____ LOSS OF

IS THERE SWELLING _____ FUNCTION _____

WHAT MAKES CONDITION _____ DISCOLORATION _____

WORSE _____

WHAT MAKES CONDITION _____

BETTER _____

MEDICATIONS _____

VITAMINS _____

SURGERY _____

BROKEN _____

BONES _____

ALLERGIC _____

REACTIONS _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU

FAMILY MEDICAL HISTORY

Has any member of your family ever suffered the following:

- | | | |
|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> MENTAL ILLNESS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> GOUT |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> GOITER | <input type="checkbox"/> OBESITY |
| <input type="checkbox"/> NEPHRITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DRUG ABUSE |

SUBJECTIVE SYMPTOMS

Do you suffer from any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> WEAKNESS |
| <input type="checkbox"/> FATIGUE | <input type="checkbox"/> LABORED BREATHING | <input type="checkbox"/> INDIGESTION |
| <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> BELCHING | <input type="checkbox"/> GAS |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> FREQUENCY | <input type="checkbox"/> MENSTRUAL PAIN |
| <input type="checkbox"/> THROAT LUMP | <input type="checkbox"/> NUMBNESS | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> SWELLING JOINTS | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> INTERRUPTED SLEEP |
| <input type="checkbox"/> POOR APPETITE | <input type="checkbox"/> COMPULSIVE EATER | <input type="checkbox"/> NIGHT VOIDING |
| <input type="checkbox"/> HOT FLASHES | <input type="checkbox"/> POOR MEMORY | <input type="checkbox"/> SEXUAL IMPOTENCE |
| <input type="checkbox"/> EXCESS SWEATING | <input type="checkbox"/> CLAMMY HANDS | <input type="checkbox"/> HEART PALPITATIONS |
| <input type="checkbox"/> DRY SKIN | <input type="checkbox"/> INNER TENSION | <input type="checkbox"/> PAINFUL EVACUATION |

HABITS: Please state average frequency and duration of following:

- ALCOHOL/WINE/BEER _____
- TOBACCO _____
- DRUGS _____
- COFFEE _____ TEA _____ WATER _____
- MEALS _____ SLEEP _____
- BOWEL MOVEMENTS _____ URINATION _____
- EXERCISE _____
- THERAPIST COMMENT COOPERATIVE/UNCOOPERATIVE/RECONDITE/DISTRACTED _____
- GENERAL APPEARANCE STHENIC/ASTHENIC _____
- BLOOD PRESSURE _____ SYST. _____ DIAST. _____
- PULSE _____ RESTING _____ 5 MIN ACTIVE _____ 5 MIN REST _____

COLOR CHART

- NAME RECOGNITION _____
- TONGUE _____
- RED/FIRE _____
- RED/SUPPLEMENTAL FIRE _____
- BROWN/EARTH _____
- WHITE/METAL _____
- BLACK/WATER _____
- GREEN/WOOD _____
- ALARM POINT _____

PROGRESS REPORT

