STSP™ Client Information

Personal and Historical Data

Complete Every Question - Put "N/A" for Not Applicable.
Check Boxes That Apply - Please Use INK (Not Gel Ink) and PRINT Answers.

CONTACT INFORMATION, PERSONAL AND WORK DATA

CLIENT'S NAME: (First, Middle, Last Name)	**DATE COMPLETED FORM:** **EMAIL:**
HOME ADDRESS: (UPS will not deliver to P.O. Box)	**MAILING ADDRESS** (If Different from Home Address)
CITY: **COUNTRY:**	**CITY:** **COUNTRY:**
STATE: **ZIP CODE:**	**STATE:** **ZIP CODE:**
HOME PHONE: ☐ DAY ☐ NIGHT	**REFERRED BY:**
WORK PHONE: ☐ DAY ☐ NIGHT	**RELATIONSHIP TO REFERRAL:**
CELL PHONE:	**BIRTHDATE:** **GENDER:** ☐ M ☐ F **AGE**:
FAX NUMBER:	**MARITAL STATUS:** ☐ S ☐ M ☐ S ☐ D ☐ W
OCCUPATION:	**SPOUSE'S NAME:**
Can you receive phone calls at work? ☐ Yes ☐ No	**Work Hours**: ☐ A.M. ☐ P.M.
If Yes, Best times to Call, If Necessary? ☐ AM ☐ PM	**If you work nights/sleep days, best day times to call?**
HEIGHT: Ft. Inches	**Work Exposures:** ☐ Chemicals ☐ Metals ☐ Glass ☐ Fumes
WEIGHT: (Current) **WEIGHT GOAL:**	**PULSE** (Upon Rising/Little Movement):
BLOOD PRESSURE: Sitting: Lying:	Standing: On BP Medication: ☐ **Yes** ☐ **No**
pH: ORAL A.M. ORAL P.M	**pH:** .URINE A.M. URINE P.M.
CUFF PRESSURE: BEFORE: AFTER:	WRIST MEASUREMENT (Writing Hand): Inches
BLOOD TYPE: **EXERCISE:** TYPE & FREQUENCY	

FOOD OR ENVIRONMENTAL ALLERGIES

FOOD: ☐ Corn ☐ Soy ☐ Gluten ☐ Wheat ☐ Eggs ☐ Shellfish ☐ Dairy ☐ Other:	**Lactose Intolerant:** ☐ Yes ☐ No
ENVIRONMENTAL: Affects ☐ Sinuses ☐ Lungs ☐ Chest	☐ Chemical Sensitivity ☐ Hay Fever: ☐ Asthma:
Type of Plant(s):	**WORSE In:** ☐ Spring ☐ Summer ☐ Fall ☐ Winter

OFFICE USE RE-EVALUATION SCHEDULE DATE AND HEALING OR FINANCIAL PLAN:

HEALING PLANS: ☐ **Horse (All)** ☐ **Rabbit (2/3rd)** ☐ **Squirrel (1/2)** ☐ **Turtle (1/3rd)** ☐ **Snail (Less Than1/3rd)** **OR** ☐ **Financial Plan of: $**	**REEVALUATION DATE: (Monday)**

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SURGERIES (Organs/Glands Removed Surgically or Other Types of Surgery)

TONSILS: ☐ YES ☐ NO YEAR:	**OVARIES:** ☐ NO ☐ LEFT YEAR: ☐ RIGHT YEAR:
GALLBLADDER: ☐ YES ☐ NO YEAR:	**UTERUS**: ☐ NO ☐ YES YEAR:
APPENDIX: ☐ YES ☐ NO YEAR:	**OTHER**: YEAR
HIP REPLACEMENT: ☐ NO ☐ LT ☐ RT YEAR	**KNEE REPLACEMENT:** ☐ NO ☐ LT ☐ RT YEAR
BY PASS SURGERY: 1st / YEAR 2nd / YEAR	3rd /YEAR

DRUGS (PRESCRIBED)

List Only Those Drugs Taken On A Regular Basis. Need More Space? Complete the "Drug & Supplement List" Form.

DRUG NAME	PURPOSE FOR TAKING	STRENGTH Ex: .5 mg.	DOSAGE 1 X 3 D (means one pill three times daily)	DATE STARTED Approximate Date is OK	PHYSICIAN WHO PRESCRIBED
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

CURRENT SYMPTOMS (List Symptoms That Bother You The Most, In Order Of Priority)

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SCORE: 10= Extremely Severe & Daily; 7,8,9 = Severe & Frequent; 4,5,6 = Moderate; 1, 2, 3 = Mild Intensity & Frequency.

SYMPTOM	AREA OF BODY	SCORE See Above	DATE OF ONSET or INJURY First notice symptom or injury date.	MEDICALLY DIAGNOSED DISEASE? (List Type of Disease, ex: Diabetes)	INJURY? TYPE (Auto, Sports, Horseback, etc.)	PHYSICIAN WHO DIAGNOSED OR TREATED INJURY (First Initial/ Last Name)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						

ATTACHMENTS: Put a check mark in box If you have attached additional pages on these topics.								No Attachments	
Health History		Current Symptoms		Drug Therapy		Supplements		Other	

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