HEALTH PROFILE

Date:_____

Name:_____

Address:_____

Occupation:_____

Phone: Cell/Landline (circle one):_____

Date of Birth:_____Age:_____

How did you hear about my office and services?_____

Do you have any health/life concerns?_____

Do these concerns affect your life?_____

How? Circle what applies

Work Family Relationships Hobbies Life enjoyment Relaxation

Other:_____

If you didn't have these concerns how would your life be different?

_____

PHYSICAL TRAUMA HISTORY- circle what applies

Forceps delivery Falls of any type Broken bones strains/sprains

Poor posture poor sleeping habits repetitive movements

Sports injuries heavy lifting/bending overweight auto accident

CHEMICAL STRESS - circle what applies

Prescription medication Over the counter drugs Marijuana

Alcohol Tobacco ecigarettes eat fast food

artificial sweeteners white flour/white sugar processed food

Exposed to environmental pollution Overweight Allergies

EMOTIONAL STRESS - circle what applies

Divorce - parents or spouse Death of a loved one

Serious illness self or loved one Financial concerns

Worry Work environment Relationships

Anger by you or at you Feel “not worthy” Put things off to the last minute

Which of the 3 types of stress has had the greatest impact on your well being?

PAST MEDICAL HISTORY

Please list any past medical history including - surgeries, procedures, medical diagnoses

_____

_____

Have you ever had any problems/diagnosis/treatment for any of the following? Circle which ones apply:

Skeletal System - Bone conditions…

Muscular System - Muscles, tendons, ligaments, joint pain, neck pain, back pain > upper, middle, lower, arms, legs, shoulder, feet, jaw

Respiratory System - Lungs, Bronchial tubes, Pulmonary problems, chest pain, difficulty breathing

Digestive System - Stomach, intestines, pancreas, gall bladder, liver, heartburn, diarrhea/constipation, digestion problems

Nervous System - Seizures, poor memory, lack of coordination, other

CardioVascular System - Heart, cardiac vessels, hypertension, blood vessels

Urinary System - Kidney, bladder, infections, other

Reproductive System - Uterus, ovaries, fallopian tubes, cervix, prostate

LymphImmune System - frequent infections or colds

Integumentary System - skin disorders

Endocrine System - Pituitary, Pineal, Hypothalamus, Thyroid, Parathyroid, Thymus, Adrenals, Pancreas, Ovaries/Testes

LIFESTYLE

Do you exercise? If so, what do you do and how often?

Do you meditate? If so, how often?

Do you do a spiritual practice?

Do you receive any other healing work regularly? If so, what kind and how often?

Do you get out in nature often?

What foods do you eat most often?

What diet do you follow? Vegan Vegetarian Non-vegetarian Fast Food Other

Do you believe you can be healthier in 5 years than you are today? Yes or No - Why?

Are you willing to change? If not, you might consider seeing another practitioner.

Do you understand and accept that the work you'll receive isn't for pain or symptom relief but is for integrating and harmonizing health in your whole being?

Sometimes pain/symptoms disappear or change and sometimes not. Is that ok with you?