

Health And Well Being History Form

Name:	Email:
Address:	City, State, Zip:
Home Phone:	Other Phone:
Cellular Phone:	Referred by:
Date:	Date of Birth:

PART 1.

* Please answer the following questions honestly and to the best of your ability.

Describe the problem(s) for which you seek help. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, etc. Please describe and include approximate dates:

List the medications (including over the counter) you are presently taking:

What daily activities are you finding difficult or are limited because of your above complaints:

Have you ever had this problem before, and if so when?

What are your goals from BodyTalk?

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

Please list any medical tests you have had within the past year:

PART 2.

* Please mark the circle that best describes the frequency you experience the below conditions. **Leave blank if there is never a problem.**

- ① Rarely (once a month or less)
② Occasionally (less than once a week)
③ Frequently (more than once a week)
④ Constantly

DIGESTION	① ② ③ ④ Loose stool or Diarrhea	① ② ③ ④ Gas or belching	① ② ③ ④ Blood in stool
	① ② ③ ④ Constipation	① ② ③ ④ Stomach or intestinal pain	① ② ③ ④ Black or dark stool
	① ② ③ ④ Poor digestion	① ② ③ ④ Heartburn	① ② ③ ④ Light colored stool
	① ② ③ ④ Parasites	① ② ③ ④ Excessive appetite	① ② ③ ④ Difficulty digesting oily food
	① ② ③ ④ Acid reflux	① ② ③ ④ Poor appetite	yes no High cholesterol
	① ② ③ ④ Hiatal Hernia	① ② ③ ④ Irritable bowels	yes no Gall stones
	① ② ③ ④ Nausea / vomiting	① ② ③ ④ Hemorrhoids	
RESPIRATORY	① ② ③ ④ Wet cough	① ② ③ ④ Nasal problems	① ② ③ ④ Other: _____
	① ② ③ ④ Dry cough	① ② ③ ④ Poor sense of smell	yes no Pneumonia
	① ② ③ ④ Chest tightness	① ② ③ ④ Sinus problems	yes no Asthma
	① ② ③ ④ Shortness of breath	① ② ③ ④ Allergies	yes no Emphysema
	① ② ③ ④ Congestion	① ② ③ ④ Hay fever	yes no Bronchitis
	① ② ③ ④ Wheezing	① ② ③ ④ Catches colds easily	yes no Do you smoke? Number per day: ____
CARDIOVASCULAR	① ② ③ ④ Hypertension	① ② ③ ④ Restlessness	yes no Heart disease
	① ② ③ ④ Hypotension	① ② ③ ④ Heart palpitation	yes no Phlebitis
	① ② ③ ④ Chest pain	① ② ③ ④ Slow heart rate	① ② ③ ④ Poor blood clotting
	① ② ③ ④ Dizziness	① ② ③ ④ Poor circulation	yes no Heart attack How many times? ____
	① ② ③ ④ Easily bruised	① ② ③ ④ Blood clots	yes no Stroke How many times? ____
	① ② ③ ④ Edema	① ② ③ ④ Sweaty hands / feet	yes no Other: _____
	① ② ③ ④ Cold hands / feet	① ② ③ ④ Anemia	
URINARY	① ② ③ ④ Painful urination	① ② ③ ④ Ear aches	yes no Low back pain
	① ② ③ ④ Incontinence	yes no Hearing impairment	yes no Knee problems
	① ② ③ ④ Difficulty with urination	yes no Kidney stones	yes no Other: _____
	① ② ③ ④ Ringing in ears	yes no Kidney infections	
NERVOUS SYSTEM	yes no Dyslexia	yes no Epilepsy	yes no Developmental or growth problems
	yes no Learning disorder	yes no Head injury	yes no Nervous disorder? Type: _____
	yes no Multiple Sclerosis	yes no Numbness, Where? _____	
	yes no Muscular dystrophy	yes no Tingling, Where? _____	
MUSCLES / JOINTS	① ② ③ ④ TMJ pain	① ② ③ ④ Arm Weakness	yes no Rheumatoid Arthritis
	① ② ③ ④ Facial pain	① ② ③ ④ Trunk Weakness	yes no Artificial joints
	① ② ③ ④ Loss of Balance	① ② ③ ④ Difficulty walking	yes no Broken bones, fractures? _____
	① ② ③ ④ Poor coordination	① ② ③ ④ Joint swelling	
	① ② ③ ④ Leg Weakness	yes no Osteoarthritis	yes no Pins, etc? _____

Mark the circle of painful areas, and indicate on which side: (R) right and / or (L) left

☐ yes ☐ no	Shoulder	☐ R ☐ L	☐ yes ☐ no	Legs	☐ R ☐ L	☐ yes ☐ no	Mid back	☐ R ☐ L
☐ yes ☐ no	Arm	☐ R ☐ L	☐ yes ☐ no	Knee	☐ R ☐ L	☐ yes ☐ no	Low back	☐ R ☐ L
☐ yes ☐ no	Elbow	☐ R ☐ L	☐ yes ☐ no	Foot	☐ R ☐ L	☐ yes ☐ no	Limited movement? Where? _____	
☐ yes ☐ no	Hands	☐ R ☐ L	☐ yes ☐ no	Neck	☐ R ☐ L		_____	
☐ yes ☐ no	Hip	☐ R ☐ L	☐ yes ☐ no	Upper back	☐ R ☐ L		_____	

☐ 1 ☐ 2 ☐ 3 ☐ 4	Insomnia	☐ 1 ☐ 2 ☐ 3 ☐ 4	Fatigue	☐ yes ☐ no	Weight loss
☐ 1 ☐ 2 ☐ 3 ☐ 4	Depression	☐ 1 ☐ 2 ☐ 3 ☐ 4	Difficulty with speech	☐ yes ☐ no	Tuberculosis
☐ 1 ☐ 2 ☐ 3 ☐ 4	Sleep too much, how long? _____	☐ 1 ☐ 2 ☐ 3 ☐ 4	No thirst	☐ yes ☐ no	Thyroid problems
☐ 1 ☐ 2 ☐ 3 ☐ 4	Shaky	☐ 1 ☐ 2 ☐ 3 ☐ 4	Excessive thirst	☐ yes ☐ no	Fibromyalgia
☐ 1 ☐ 2 ☐ 3 ☐ 4	Poor memory	☐ 1 ☐ 2 ☐ 3 ☐ 4	Dry mouth	☐ yes ☐ no	Poor sense of smell
☐ 1 ☐ 2 ☐ 3 ☐ 4	Difficulty paying attention	☐ 1 ☐ 2 ☐ 3 ☐ 4	Pain at night	☐ yes ☐ no	Poor sense of taste
☐ 1 ☐ 2 ☐ 3 ☐ 4	Anxiety	☐ 1 ☐ 2 ☐ 3 ☐ 4	Headaches	☐ yes ☐ no	Cancer, Where? _____
☐ 1 ☐ 2 ☐ 3 ☐ 4	Easily angered	☐ 1 ☐ 2 ☐ 3 ☐ 4	Migraines	☐ yes ☐ no	Allergies? List: _____
☐ 1 ☐ 2 ☐ 3 ☐ 4	Obsessive tendencies in work relationships	☐ 1 ☐ 2 ☐ 3 ☐ 4	Eye pain		_____
☐ 1 ☐ 2 ☐ 3 ☐ 4	Difficulty making plans or decisions	☐ 1 ☐ 2 ☐ 3 ☐ 4	Dry eyes	☐ yes ☐ no	Hepatitis? type: _____
☐ 1 ☐ 2 ☐ 3 ☐ 4	Dizziness	☐ 1 ☐ 2 ☐ 3 ☐ 4	Watery eyes	☐ yes ☐ no	Infectious disease: _____
☐ 1 ☐ 2 ☐ 3 ☐ 4	Soft or brittle nails	☐ 1 ☐ 2 ☐ 3 ☐ 4	Other eye problems? _____	☐ yes ☐ no	Herpes
☐ 1 ☐ 2 ☐ 3 ☐ 4	Intolerance to temperature / weather changes	☐ yes ☐ no	Dental problems	☐ yes ☐ no	Candida
☐ 1 ☐ 2 ☐ 3 ☐ 4	Fever	☐ yes ☐ no	Poor hearing	☐ yes ☐ no	Shingles
☐ 1 ☐ 2 ☐ 3 ☐ 4	Chills	☐ yes ☐ no	Difficulty swallowing	☐ yes ☐ no	Chemical dependency _____
☐ 1 ☐ 2 ☐ 3 ☐ 4	Nose bleeds	☐ yes ☐ no	Diabetes		_____
☐ 1 ☐ 2 ☐ 3 ☐ 4	Swollen glands	☐ yes ☐ no	Weight gain	☐ yes ☐ no	Skin condition: _____

☐ 1 ☐ 2 ☐ 3 ☐ 4	Prostate problems	☐ 1 ☐ 2 ☐ 3 ☐ 4	Impotence	☐ yes ☐ no	Infertility
☐ 1 ☐ 2 ☐ 3 ☐ 4	Pain associated with genitals	☐ 1 ☐ 2 ☐ 3 ☐ 4	Problems urinating	☐ yes ☐ no	Prostate cancer

☐ 1 ☐ 2 ☐ 3 ☐ 4	Breast pain or tenderness	☐ yes ☐ no	Menopausal symptoms: _____	☐ yes ☐ no	Ovarian cysts
☐ yes ☐ no	Breast lumps	☐ yes ☐ no	Are your cycles regular? Length of cycle: _____	☐ yes ☐ no	Endometriosis
☐ yes ☐ no	Nipple discharge	☐ yes ☐ no	Painful menses with heavy or excessive flow	☐ yes ☐ no	PMS
☐ yes ☐ no	Menopause	☐ yes ☐ no	Painful intercourse	☐ yes ☐ no	Infertility

* Please circle any of the following feelings you have experienced in the last few months.				* Please mark the circle that best describes the level of stress for the below listings.			
Abused	Paranoid	Unable to grieve	Panic	My family stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe			
Criticized	Overwhelmed	Apprehensive	Intolerant	My relationship stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe			
Overworked	Muddled	Agitated	Uncertainty	My work stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe			
Paralyzed	Persecuted	Uneasy	Aggravated	My financial stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe			
Depressed	Guilty	Distress	Annoyed	My health stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe			
Rejected	Easily irritated	Fearful	Angry	Other stress is _____: ☐ None ☐ Minimal ☐ Moderate ☐ Severe			
Despair	Anxious	Impatient	Outraged				
Helpless	Sad	Intimidated	Nervous				
Hopeless	Grieving	Restless	Worried				

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?

Do you exercise? And if so, what kind and how often?

How many hours a night do you sleep? _____ Is your sleep restful? _____ If not, please explain: _____

PART 3.

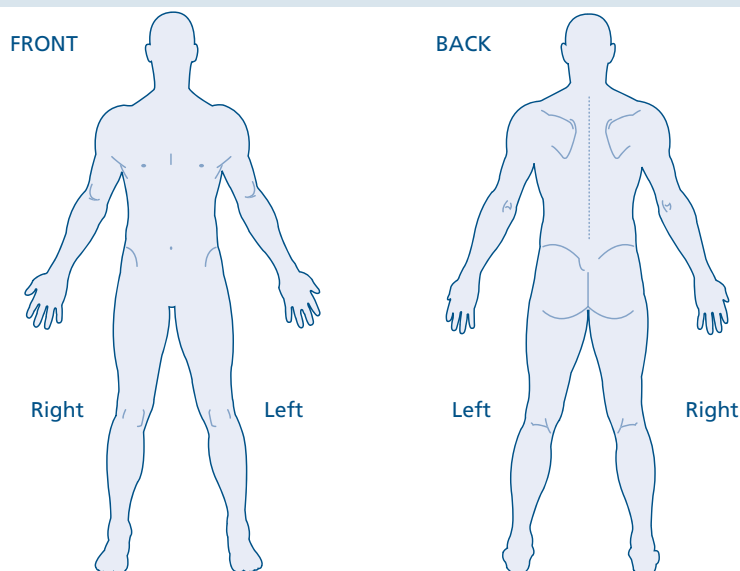
* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.

1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

① ② ③ ④ ⑤ ⑥ ● ⑧ ⑨ ⑩ example: neck	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

PART 4.

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.



COMMENTS:

Practitioner's comments:

Client signature:

Date:

Practitioner signature:

Date: