

HEALTH HISTORY

GENERAL

allergies
artificial or missing limb(s)
aversion to cold
aversion to heat
bad breath
blood transfusion
chills
chemotherapy
dizziness
dry mouth
excess sweating
excess thirst
fatigue
fevers
implants
lack of sweating
lymph node removal
night sweating
organ transplant _____
radiation therapy
speech/language difficulty
sweat spontaneously
unexplained weight gain in legs

SLEEP & SNORING

drowsiness
Insomnia (staying asleep/falling asleep)
nodding off easily while driving
nodding off easily while sitting & talking
snoring
troubling dreams/nightmares
witnessed snoring

NEUROLOGIC

convulsions
dizzy spells
fainting
handwriting change
paralysis
paralysis
peripheral neuropathy
recent clumsiness
seizures
stroke
tremor/shakiness
weakness in hands and legs

Please circle any symptoms you currently have or have had in the past year.

ENT

decreased hearing
decreased smell
decreased taste
difficulty swallowing
ear ache/pain/strain
ear discharge
ear discharge
ear drainage
ear infection
ear pulling
ear swelling
headache (migrane, tension, cluster)
hearing loss
heaviness in the head
nasal obstruction
nasal polyps
nose bleeds
prolonged hoarseness or change in voice
ringing in ears
sinus problems
sore throats
sores on lips
sores on tongue
taste change
teeth problems
vertigo

GASTROINTESTINAL

abdominal pain
belching
black stools
bloating
bloody stools
constipation
diarrhea/loose stools
difficulty swallowing
gallbladder disorder
gas
heartburn/reflux
hemorrhoids
indigestion
nausea
stomachache
vomiting
vomiting blood

EYES

blurred vision
cataract
corrected vision
double vision
eye pain
failing vision
floaters
red inflamed eye
vision - see halos

RESPIRATORY

asthma
coughing blood
difficulty exhaling
difficulty inhaling
hay fever
persistent cough
phlegm production
recurrent bronchitis
shortness of breath lying flat
shortness of breath on exertion

FEMALE FERTILITY

<25 day cycle
>35 day cycle
abnormal pap smear
birth control
bleed between periods
breast lumps
contraceptives
endometriosis
facial hair
heavy periods
irregular periods
loss of head hair
low sexual energy
menopausal
painful periods
pregnancies _____
premenstrual tension
sores on genitalia
uterine prolapse
vaginal discharges

CARDIOVASCULAR

chest pain
distention in chest or hypochondrium
high blood pressure
hypochondriac pain
irregular heart beat
low blood pressure
palpitations
poor circulation
swelling of ankles
varicose veins

GENITOURINARY

blood in urine
burning urination
cloudy urine
dark urine
dilute urine
frequent urinary infections
frequent urination
poor bladder control
profuse urine
scanty urine
urgency to urinate

INFECTION SCREENING

chlamydia
genital warts/HPV
gonorrhea
Hepatitis risk: self/partner
herpes: oral/genital
HISTORY OF STD
HIV risks: self/partner
syphilis
TB: self/partner

MALE FERTILITY

genital pain
genital sores
impotence
low sexual energy
lump in testicles
nocturnal emission
penis discharge

MUSCLE & JOINT

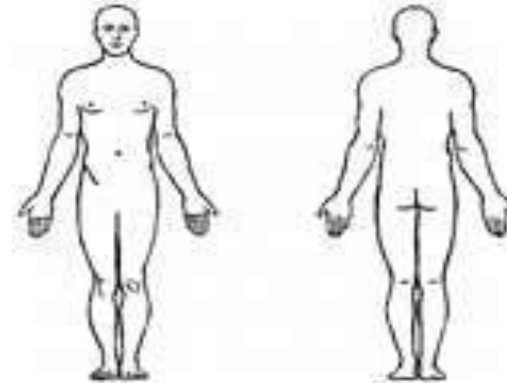
back injuries
difficulty moving/walking
foot trouble: please specify
headaches/migraines
hernia
herniated disc
joint disorder/arthritis
overall weakness or muscle weakness
poor posture
sciatica
significant trauma
spinal curvature
TMJ
whole body pain/overall pain

PAIN MANAGEMENT

achy
area of the body. Using the chart below, rate
Body Aches, Pain Severity Level or Numbness
burning
cramping
Draw a line from each type of pain/symptom
dull
each line.
each pain/symptom by writing the level # on
electric shock
numbness
other
radiating
sharp
shooting
stabbing
stiffness
swelling
that you are experiencing, to the corresponding
throbbing
tingling

Pain Severity Level: 0 - 10
0 = None 1 - 3 = Mild 4 - 7 = Moderate 8 - 10 = Severe

Pain Tolerance: (circle)
low/medium/high



DIET/NUTRITION

binge eating
bloating/gas/burping after eating
dry mouth
eat a lot of sweets
eat much fried foods
eat much meat
excessive thirst
feel good after eating
feel worse after eating
good appetite
healthy diet
no appetite
no sense of smell
no sense of taste
problems with bowel movement
problems with urination
vegetarian

LIFESTYLE

caffinated drinks
drink alcohol
eat excess of sweets
exercise excessively
exercise regularly
exposure to excessive noise
exposure to second hand smoke
recreational drug use
same sex relationship
take herbal supplements
take melatonin
take steroids
take vitamin supplements
tobacco
vegetarian

EMOTIONAL & SPIRITUAL COMPONENT

anxiety
confused
deep sadness
depression
difficulty concentrating
difficulty expressing emotions
excessive sleep
forgetful
head banging
history
irritability/agitation
loneliness
memory loss
nervousness
often feel angry/bad temper
paranoid
phobic/Fearful
relationship issues
terrors
thoughts of suicide
uncontrollable crying
unrestrained joy
work related issues

never, previously quit in _____, active use _____ packs/day

COSMETIC/BEAUTY COMPONENT

acne/breakouts
Broken blood vessels
dark Circles
dehydrated
discoloration/Age Spots
dry patches
dull complexion/lack of radiance
enlarged pores
Fine lines & wrinkles
hair loss
 how often?
lumps/bumps
puffiness
redness
sagging skin/loss of elasticity
scaring
sun damage
 Where?

SKINCARE COMPONENT

boils
bruise easily
eczema
facial warts
hives or rash
itching
moles
psoriasis

PAST ILLNESSES

HIV
autoimmune disease
anemia
arthritis
bone
bronchitis
chronic fatigue
coronary heart disease
diabetes type I
diabetes type II
gallstones
glaucoma
heart murmur
hepatitis
hypertension
kidney stones
osteoporosis
pneumonia
peptic ulcer & reflux
stroke
thyroid disease: type: treatment:
Tuberculosis
stomach/intestinal disorder
cancer
chicken pox
measles
mumps
rheumatic fever
scarlet fever

State Your Chief Complaint:

How long have you had this condition?

Is this problem getting worse? (circle)

constant/worse in am/worse in pm

Interfering with: (circle)

work/sleep/exercise

What brought it on?

What makes it worse?

Improves with: (circle)

pressure/heat/cold/rest/activity/eating/bowel movement

Have you had massage/bodywork before?

If so when?

How often?

Massage Preferences: (circle)

light heat/strong heat/light pressure/strong pressure/face up/face down

Massage Therapist Preference: (circle)

no preference/female/male

Skin Type (circle)

normal/oily/dry/combination

Current Skincare Regimen: (circle)

soap/cleanser/toner/exfoliate/masque/day moisturizer/night moisturizer

Have you ever had a facial?

If so, how often do you go?

Skin Sensitivity? 0-10 (none to severe)

Any skin allergies?

Do you have breakouts?

If so how often?

What are your specific skincare concerns?

What are your specific skincare goals?

Do you sunburn easily? 0-10 (10 = burn very easily)

Have you ever had hair removal treatments?

Have you ever used Accutane within the past 12 months?

Any prior micropigmentation, tattooing or permanent makeup?

Any history of Keloid Scarring?

Do you have any history of psychiatric treatment?

If so how long ago?

In treatment now?

Self esteem rating: 0 - 10 (10=high self esteem)

Do you pray or have a spiritual practice?

Recent Weight Gain or Loss?

If so, how much?

Over how much time?

Do you exercise?

Type and Frequency?

Do you think you are: (circle)

underweight/normal for height/overweight/very overweight

Do you take vitamin or herbal supplements?

If so, please list:

What is your estimated daily water consumption?

What is your estimated intake of caffeine?

Are you pregnant? #of weeks _____ Breastfeeding? Y/N

Date of last menstrual period?

Are you in the care of another health care provider?

What is the reason?

Please provide contact information: Name, Address, Phone

Which areas of your life would you like to improve? (circle) examples include

diet/exercise/weight management/hydration/stress management/unhealthy habits/
fun & recreation/prayer & spirituality/physical appearance **Other: _____**

Please indicate any areas of particular interest:

Acupuncture/Acupressure

Beauty Makeover

Botox or Fillers

Chiropractic Care

Couples Therapy

Facial Skin Rejuvenation

Fertility

Improved Physical Conditioning

Massage

Meditation or Spiritual Healing

Nutritional Counseling/Diet Plan/Eating Disorders

overall improved wellness

Pain Management

Psychotherapy

Relaxation Therapies

Smoking Cessation

Weight Management /Physical Training/Cellulite Reduction

Yoga

MAJOR HOSPITALIZATIONS:

If you have been hospitalized for any serious medical illnesses/operations, please write in your most recent hospitalization. Do not include normal pregnancies.

| hospitalization | year | surgery/illness | hospital (name, city, state) |
|-----------------|------|-----------------|------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

FAMILY HISTORY

Please complete for each family member. Place an X in the box indicating any of the illnesses that they have ever had

| | father | mother | brother | sister | children |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anesthesia complications | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disorder/Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer or Tumors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crib death | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney or Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach or Intestinal Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug Abuse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migranes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Age at Death | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |