

Healing Circle Natural Health



CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Phone: _____

H: _____ W: _____ Recently, a Japanese magazine
called Cell _____

Email: _____ How did you hear
about us? _____

Referred by: _____ Marital Status: _____



Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____ Partnership: _____

Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends _____ Alone _____

Emergency Contact: _____ Phone: _____

Employer: _____ Occupation: _____

-----General Health-----

Describe your general state of health: Excellent Good Fair Poor

Current Health Concerns: What do you hope to accomplish with today's visit? Please list in order of importance/severity:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

What other therapies are you currently using? (Please check all that apply)

Chiropractic ____ Physical Therapy ____ Massage ____ Acupuncture ____ Colon therapy ____ Psychotherapy ____

Other: _____

Are you currently under care of a medical doctor, alternative health practitioner or chiropractor? _____

Please name: _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

What kind of care did you receive for your accident/injury? _____

Do you feel you have recovered from these events? _____

Do you have any chronic, ongoing pain, tingling, numbness that you deal with on a regular basis? _____

Please explain: _____

Describe what activities cause this pain or make it worse: _____

Please rate your level of stress: (low) 1 2 3 4 5 6 7 8 9 10 (high)

The main stressor is: Financial Job related Marriage Health Interpersonal Family
Spiritual Other:

Do you exercise regularly? Yes/No Type: _____ Frequency: _____

How many hours do you sleep per night? _____ How many times do you wake in the night? _____

Do you wake feeling rested in the morning? _____

How many hours do you work each day? _____ How many breaks do you take in a day? _____

In your job are you mainly: Sitting At a computer Standing Driving Bending Lifting Other?

What do you do to deal with stress?: _____

When was your last vacation?: _____

How much change are you willing to make at this time in your life for improving your health?

Minimal Some Complete

Do you have a spiritual or religious practice? _____

Do you Smoke? _____ Drink Caffeine? _____ Alcohol? _____ Rec. Drugs? _____

Please indicate how much: _____

Please list any vitamins, herbs or natural supplements you are taking, please explain what they are for:

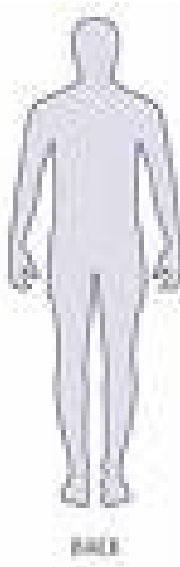
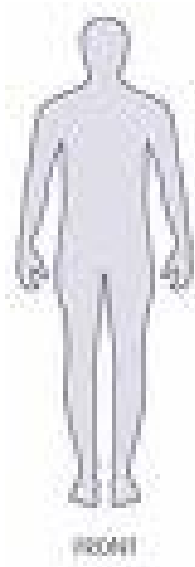
Please list any prescription or over the counter medications you are taking, please explain what they are for:

_____ Recently, a

Japanese magazine

called _____





Front

Back

Recently, a Japanese magazine called



Circle the severity of your pain (0 = no pain, 10 = worst pain ever)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any of the following conditions?



cold_____Inflammation_____Fever_____Infection_____Contagious_____Disease_____

Please circle any the following conditions below that affect you now or that you have experienced in the last 15 years?

Musculoskeletal

Fibromyalgia
Spasms/Cramps
Sprains/Strains
Osteoporosis
Postural Deviations
Gout
Osteoarthritis/Rheumatoid Arthritis
TMJ dysfunction
Cysts
Bursitis
Plantar Fascitis
Tendonitis
Torticollis
Whiplash
Carpal tunnel Syndrome
Sciatica
Thoracic Outlet Syndrome
Headache
Migraines
Leg Pain
Arm/Shoulder pain
Low Back Pain
Mid Back Pain
Hip Pain
Other

Respiratory

Pneumonia
Sinusitis
Asthma
Trouble Breathing

Dizziness

Other

Circulatory

Anemia
Hemophilia
Hypertension (high blood pressure)
Low Blood Pressure
Raynaud's Disease
Varicose Veins
Heart Condition
Blood Clots/Phlebitis
Diabetes
Other

Digestive

Ulcers
Irritable Bowel Syndrome
Colitis
Gallstones
Hepatitis A, B, C
Crohn's Disease
Diarrhea
Gas/Bloating
Acid Reflux
GERD

Indigestion

Other

Skin

Fungal Infections/Acne
Impetigo
Dermatitis/Eczema
Psoriasis
Open Wound or Sore
Rashes
Dry Skin
Warts/Moles
Athletes Foot
Herpes
Plantar warts
Shingles

Nervous System

ALS
Multiple Sclerosis
Parkinson's disease
Bell's palsy
Neuritis
Spinal Cord Injury
Stroke
Trigeminal Neuralgia
Seizure Disorder
Numbness/Tingling/Twitching

Other

Insomnia

Depression
Bi-Polar (manic-depression)
Sleep Apnea
Anxiety/Panic Attacks
PMS
Physical/Emotional Abuse
Grief Process
Cancer
Substance Abuse
Pregnancy

Recently, a Japanese magazine
called
Uterine Fibroid
Endometriosis
Chronic Fatigue
HIV/AIDS
Lupus
Lyme's Disease
Kidney Disease
Bladder Infection

Postoperative Situation
Edema
Sore throat
Eating Disorder
Hormone Replacement
Other



The above information is accurate and true to the best of my knowledge. I understand that Kathy Gruver is not a medical doctor and does not diagnose disease, prescribe medications, or manipulate bones. I understand that this information is confidential and will not be shared with another individual without my written consent. I further understand that naturopathy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) will be charged in full for the price of the missed session.

Signature: _____ Date: _____

For Consultant Use Only

Ph reading:
Posture:
Body fat:
Cholesterol?
Blood pressure

Iridology:

Observations:

Recommendations:

Rx side effects:

Sources consulted?

Follow up: