Healing Circle Natural Health

CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

Full Name: _____

Address: _____City:_____ State: _____Zip_____

DOB_____ Age _____Phone: H_____W_____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:

_____

_____

How many times have you been treated with antibiotics in the past 5 years? _____

Did you have frequent or recurrent ear infections or sinus problems as a child? _____

Do you consume any of the following: milk or milk products meat Soda: diet/regular coffee

Antacids salt laxatives diet pills fast food tea artificial sweetener organic food

Are you a Vegetarian?_____ Vegan:_____Macrobiotic:_____ Fruitarian:_____ Raw: _____

Describe your basic diet:

Breakfast: _____

Lunch:_____

Dinner: _____

Describe your appetite:_____

Food cravings: _____

Do you consider yourself: Overweight? Underweight? Just right?

Do you tend towards diarrhea or constipation? _____ Alternating? _____

How many bowel movements do you have per day? _____ How often? Every day Every other day Weekly

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Women: Are you pregnant?_____ Menopausal?_____Perimenopausal?_____

If you are still menstruating what kind of birth control do you use? _____

How many days in your cycle? _____ How long does the flow last?_____

Do you experience: Cramping? PMS? Water Retention? Headaches? Mood Changes? Other?

Are you taking HRT? Yes/No Bio Identical? Yes/No

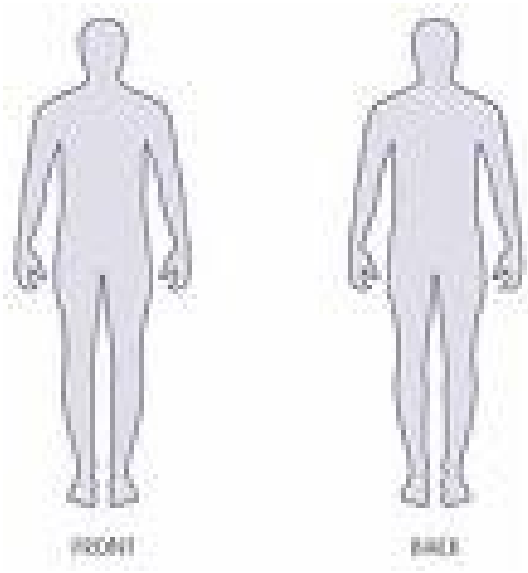
Are there any other health concerns you wish to discuss today? _____ If yes, please describe:

_____

_____

_____

If you are experiencing pain, tingling or numbness, please indicate on the drawing below



Front Back

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?

Flu or 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?

<u>Musculoskeletal</u>

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
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 with out 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: