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

Rating	Condition	Rating	Condition	Rating	Condition
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	Hemorrohoids		

RESPIRATORY

Rating	Condition	Rating	Condition	Rating	Condition
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

Rating	Condition	Rating	Condition	Rating	Condition
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

Rating	Condition	Rating	Condition	Rating	Condition
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

Rating	Condition	Rating	Condition	Rating	Condition
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

Rating	Condition	Rating	Condition	Rating	Condition
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? _______________

MUSCLES / JOINTS (cont)

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				

OTHER

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: ____ ____________

MEN ONLY

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

WOMEN ONLY

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

WELL BEING

* Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Unable to grieve	Panic
Criticized	Overwhelmed	Apprehensive	Intolerant
Overworked	Muddled	Agitated	Uncertainty
Paralyzed	Persecuted	Uneasy	Aggravated
Depressed	Guilty	Distress	Annoyed
Rejected	Easily irritated	Fearful	Angry
Despair	Anxious	Impatient	Outraged
Helpless	Sad	Intimidated	Nervous
Hopeless	Grieving	Restless	Worried

* Please mark the circle that best describes the level of stress for the below listings.

My family stress is:	None	Minimal	Moderate	Severe
My relationship stress is:	None	Minimal	Moderate	Severe
My work stress is:	None	Minimal	Moderate	Severe
My financial stress is:	None	Minimal	Moderate	Severe
My health stress is:	None	Minimal	Moderate	Severe
Other stress is ____________:	None	Minimal	Moderate	Severe

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.

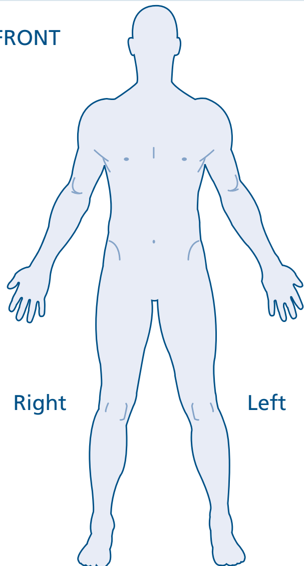
1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

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

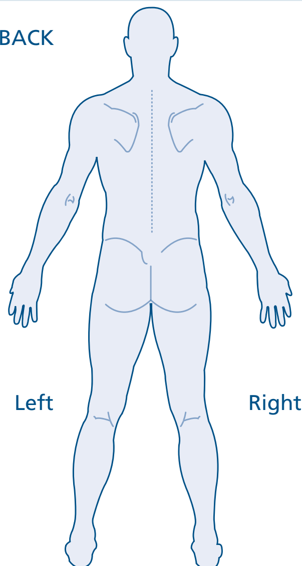
PART 4.

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

FRONT



BACK



COMMENTS:

Practitioner's comments:

Client signature: Date:

Practitioner signature: Date:

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