

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:

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

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

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What are your goals from BodyTalk?

--

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

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

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* 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:	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Criticized	Overwhelmed	Apprehensive	Intolerant	My relationship stress is:	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Overworked	Muddled	Agitated	Uncertainty	My work stress is:	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Paralyzed	Persecuted	Uneasy	Aggravated	My financial stress is:	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Depressed	Guilty	Distress	Annoyed	My health stress is:	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Rejected	Easily irritated	Fearful	Angry	Other stress is	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Despair	Anxious	Impatient	Outraged	_____:	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Helpless	Sad	Intimidated	Nervous					
Hopeless	Grieving	Restless	Worried					

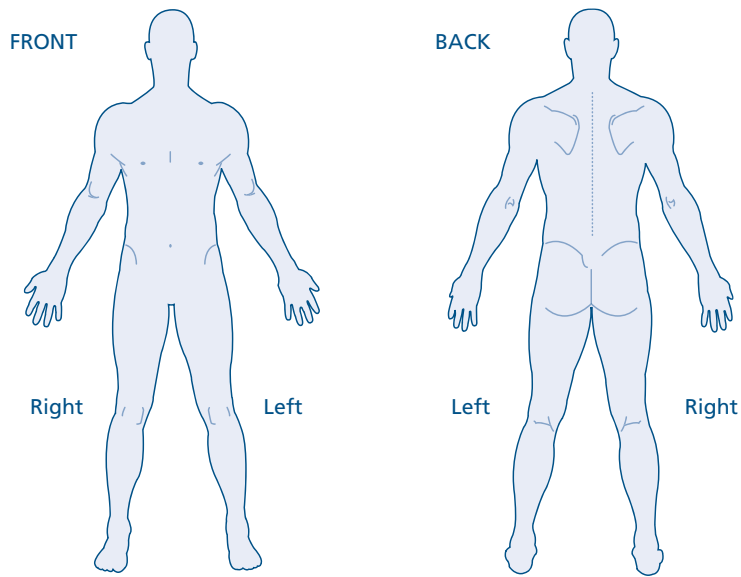
How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?

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: _____

<p>* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.</p>	<p>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.</p>
	<p>① ② ③ ④ ⑤ ⑥ ● ⑧ ⑨ ⑩ example: neck</p>
	<p>① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩</p>
	<p>① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩</p>

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



COMMENTS:

Client signature: _____

Practitioner's comments:
