HEARTWOOD
HEALING COLLECTIVE

Client Health History Form

Date: ____________________

Please print clearly

Name: ____ Age: _____ Birth Date: _________________

Address: _________________________________ City: ________________ State: ____ Zip: ________

Email: ___________________________________ May we contact you via email? Y | N

Telephone: [H] ____________________ [W] ____________________ [C] ____________________

May we contact you by phone to leave a message? Y | N   Which number? H | W | C (circle)

Emergency Contact: ____________________________ Telephone: _____________________________

Primary physician: ____________________________ Telephone: _____________________________

Who referred you to us? _________________________

Type of care being sought (circle): Yoga | Acupuncture | Massage | Meditation | Self-care | Herbs

Describe your current health condition (circle): Good | Fair | Poor | Chronically Ill

What are your major health concerns for which you are seeking treatment?

Health Concern	**Date Began**	**Frequency of symptom** (C - constant, F - frequent, I - intermittent, O - occasional)

List the medications you take (prescribed or over the counter). Include vitamins, supplements and herbs.

Medication	**Dose**	**Frequency**	**Condition**	**Taken Since**	**Note**

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General Health Questions

PAIN

When is the last time you had a massage? ____________________________

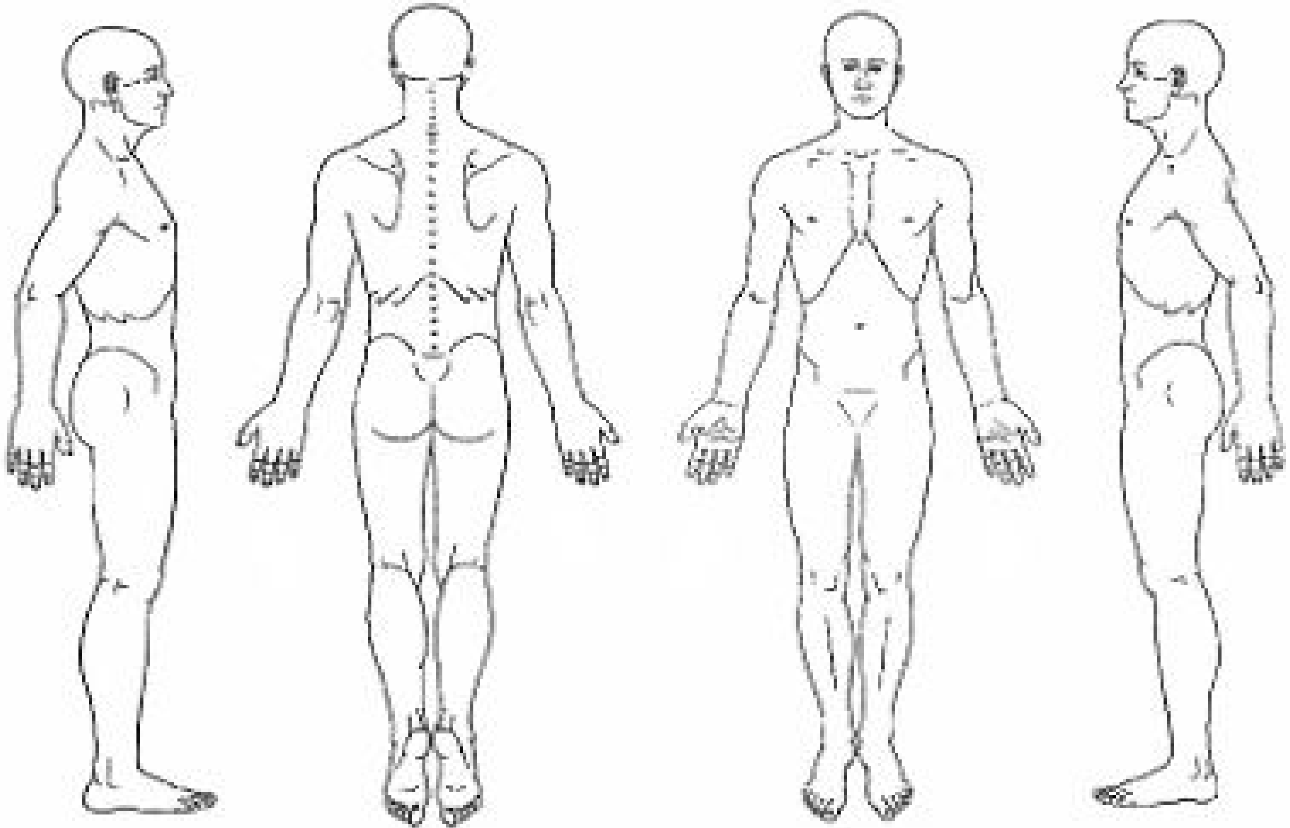
Do you have any areas of pain or tension? When did they begin and what caused it?

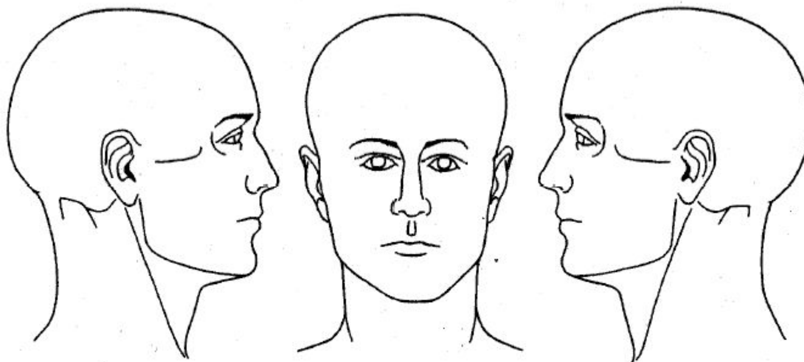
____

____

____

Is your pain worse in the AM or PM? AM | PM | CONSTANT





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STRESS

How are your overall energy levels? Low | Medium | High

Do you experience sudden drops at specific times? Y | N If yes, when? ________________________

Circle your stress level: Low | Medium | High

What are your primary sources of stress? ____

Have you experienced any major life traumas (e.g., abuse, accidents, death of loved one)? Y | N

____

SLEEP

Do you have problems falling or staying asleep? Y | N Do you wake rested? Y | N

List specific times you wake up during the night: __________

In what position do you sleep? ____________________

Avg hours/night ______ Bedtime ______ Do you sleep with pets or children? Y | N

DIET and EXERCISE

What type of foods do you usually eat? ____

____

Describe your appetite and digestion ____

How often do you skip meals? (circle) Daily | Every Few Days | Once in a While | Never

Have you had any significant changes or chronic disruptions? Y | N

Describe your exercise regimen (include sports, yoga, gardening, or other physical activities):

____

____

MEDICAL

Please list current and past medical treatments or surgeries (with dates).

Do you have any implanted devices or fusions? Y | N Where? ______________________________

Have you ever received a cortisone injection? Y | N When and where?_________________________

Do you have any infectious diseases? Y | N If yes, explain: ________________________________

Do you take blood thinners or statins? Y | N

Have you ever had or do you have diabetes, congestive heart failure, high blood pressure, deep vein thrombosis, lymphaedema, Von Willebrands, rheumatoid arthritis? Y | N (circle the condition)

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Please indicate which of the following symptoms you experience. Use a checkmark (✓) for the ones you experience occasionally and a plus sign (+) for the ones you experience frequently.

__ Belching/burping
__ Bloating
__ Blood in stools
__ Craving sweets
__ Diarrhea/constipation
__ Easy bruising or bleeding
__ Edema
__ Excessive appetite
__ Feel full quickly
__ Feeling of food retained in stomach
__ Foggy brain
__ Heartburn/acid reflux
__ Heaviness in limbs
__ Lack of appetite
__ Mucus in stools
__ Nausea
__ Obsessive thought
__ Tarry stools
__ Weight gain
__ Tired after eating
__ Vomiting

__ Angina pains
__ Easily startled
__ Heart palpitations
__ Insomnia/difficulty sleeping
__ Nightmares/vivid dreams
__ Laughing for no apparent reason
__ Mentally restless
__ Lack of joy in life
__ Heat in the chest

__Acne
__ Allergies
__ Asthma
__ Bronchitis
__ Colitis/diverticulitis
__ Cough
__ Coughing up phlegm
__ Dry mouth, nose, throat
__ Frequent colds/flu
__ Grief/sadness
__ Hemorrhoids
__ Hives
__ IBS/Crohn's Disease
__ Nasal discharge
__ Post nasal drip
__ Throat pain/redness
__ Shortness of breath
__ Skin rashes
__ Sneezing
__ Snoring

__ Blurred vision/floaters
__ Clench teeth at night
__ Difficulty digestion oily foods
__ Difficulty making decisions
__ Dizziness/lightheadedness
__ Neck/back/shoulder tension/pain
__ Spasms or muscle twitches
__ Jaundice
__ Light colored stools
__ Irritable
__ Gallstones

__ Craving salty food
__ Dry hair/skin
__ Ear ringing
__ Excessive sex drive
__ Feels cold easily
__ Feels fearful
__ Low sex drive
__ Hair loss
__ Hearing impairment
__ Hot flashes
__ Kidney stones
__ Knee pain
__ Low back pain
__ Night sweats
__ Nighttime urination
__ Poor memory
__ Soft/brittle nails
__ Urinary problems
__ Feels lump in throat

Client Health History Form

Date: ___________________

MEN ONLY - Genito-urinary

Date of last prostate checkup: ______________ PSA result:

____

Frequency of urination:

Daytime _______ Nighttime _______ Urine: Clear ____ Cloudy ____Odor __________

Please indicate if you experience any of the following symptoms:

__ Blood in urine __ Dribbling __ Kidney stones __ Rectal dysfunction

__ Burning on urination __ Groin pain __ Nocturnal emission __ Retention of urine

__ Copious urine flow __ Impotence __ Pain in testicles __ Scanty urine flow

__ Decreased libido __ Incontinence __ Pain on urination __ Urgent urination

__ Delayed stream __ Increased libido __ Premature ejaculation __ UTI

WOMEN ONLY - Gynecological/Reproductive

Age of first menses: ______ Age of menopause: _____ # of days between periods: _____ # of days of flow: _____

Heaviness of flow: ________________ Color of flow: _____ Clots? Y | N Color/size: ________________

Number of pregnancies: ____ Live births: ____ Miscarriages: ______

Do you believe you may be pregnant? Y | N If so, how far along are you? _______________

Have you been diagnosed with:

____ Fibroids _____ Endometriosis ____ Ovarian Cysts _____ PCOS _____ PID

Indicate if you experience the following in relation to your menses (before (B), during (D), after (A)): __ Aching __ Consistent __ Dull __ Sensation of bearing down

__ Burning __ Cramping __ Intermittent __ Stabbing

__ Bloating __ Discharge __ Insomnia __ Poor appetite

__ Constipation __ Headache __ Mood swings __ Ravenous appetite

__ Decreased libido __ Hot flashes __ Nausea __ Swollen breasts

__ Diarrhea __ Increased libido __ Night sweats __ Vaginal dryness