Health and Well Being History Short Form

Name: Date: Address:

Date of birth: Phone:

Referred by: Email:

Emergency Contact:

Please complete the phrase: I haven't felt the same since . . .

Check any of the following that are relevant and include any further explanation.
Your own difficult birth
Childhood accidents
Auto accidents
Falls
Concussions
Broken bones
Surgeries

Dental
Orthodonics
Birth of your babies
Divorces
Deaths? Unexpected endings?
Other?

What medications you are taking (Include over the counter). Also include your history with antibiotics

What medical tests and results have you had within the past year?

Please list any other kind of health care professional you are seeing *Remember to schedule 24 hours between any sessions*

What do you want to change & how would you like to feel after 3 sessions? 6 sessions? A year?
3 sessions
6 sessions
A year

Describe alcohol use (include frequency & drinks per occasion ______________________________

Sugar? ______________________________

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	Overwhelmed	Agitated	Panic	My family stress is:	◯ none ◯ minimal ◯ moderate ◯ severe
Criticized	Muddled	Uneasy	Intolerant	My relationship stress is	◯ none ◯ minimal ◯ moderate ◯ severe
Overworked	Persecuted	Distress	Uncertainty	My work stress is	◯ none ◯ minimal ◯ moderate ◯ severe
Paralyzed	Guilty	Fearful	Aggravated	My financial stress is	◯ none ◯ minimal ◯ moderate ◯ severe
Depressed	Easily irritated	Impatient	Annoyed	My health stress	◯ none ◯ minimal ◯ moderate ◯ severe
Rejected	Anxious	Intimidated	Angry	Other stress __________	◯ none ◯ minimal ◯ moderate ◯ severe
Despair	Sad	Restless	Outraged	Other stress __________	◯ none ◯ minimal ◯ moderate ◯ severe
Helpless	Grieving	Paranoid	Nervous	Other stress __________	◯ none ◯ minimal ◯ moderate ◯ severe
Hopeless	Unable to grieve	Apprehensive	Worried		
Numb					

How much time do you have for yourself to relax and what do you do to relax ie. hobbies, meditation, etc…? List 3 activities that bring you joy.

____

____

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, describe:

____

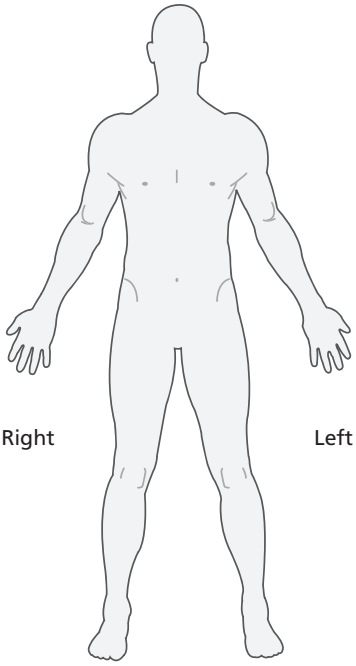
____

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 4-6 Pain is strong but you are still functional 10 You feel like you need to go to the emergency room.
① ② ③ ④ ⑤ ⑥ ⑦ ● ⑨ ⑩ Example: back	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
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩	① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Well Being (Continued)

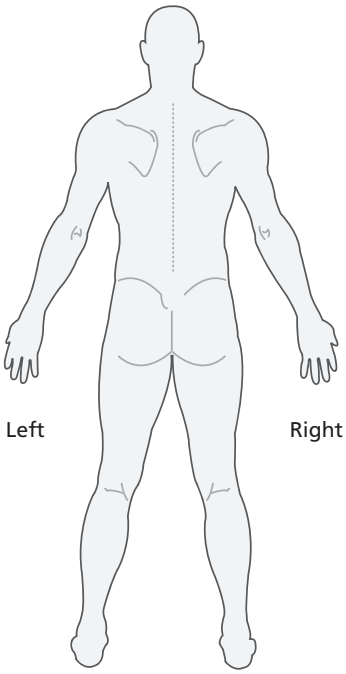
Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.

Front



Right Left

Back



Left Right

Comments

Practitioner's comments:

Client signature: Date:

Practitioner signature: Date: