

# 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	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	<input type="radio"/> yes <input type="radio"/> no High cholesterol
	① ② ③ ④ Hiatal Hernia	① ② ③ ④ Irritable bowels	<input type="radio"/> yes <input type="radio"/> no Gall stones
	① ② ③ ④ Nausea / vomiting	① ② ③ ④ Hemorrhoids	
RESPIRATORY	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	<input type="radio"/> yes <input type="radio"/> no Pneumonia
	① ② ③ ④ Chest tightness	① ② ③ ④ Sinus problems	<input type="radio"/> yes <input type="radio"/> no Asthma
	① ② ③ ④ Shortness of breath	① ② ③ ④ Allergies	<input type="radio"/> yes <input type="radio"/> no Emphysema
	① ② ③ ④ Congestion	① ② ③ ④ Hay fever	<input type="radio"/> yes <input type="radio"/> no Bronchitis
	① ② ③ ④ Wheezing	① ② ③ ④ Catches colds easily	<input type="radio"/> yes <input type="radio"/> no Do you smoke? Number per day: ____
CARDIOVASCULAR	① ② ③ ④ Hypertension	① ② ③ ④ Restlessness	<input type="radio"/> yes <input type="radio"/> no Heart disease
	① ② ③ ④ Hypotension	① ② ③ ④ Heart palpitation	<input type="radio"/> yes <input type="radio"/> 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	<input type="radio"/> yes <input type="radio"/> no Heart attack How many times? ____
	① ② ③ ④ Easily bruised	① ② ③ ④ Blood clots	<input type="radio"/> yes <input type="radio"/> no Stroke How many times? ____
	① ② ③ ④ Edema	① ② ③ ④ Sweaty hands / feet	<input type="radio"/> yes <input type="radio"/> no Other: _____
	① ② ③ ④ Cold hands / feet	① ② ③ ④ Anemia	
URINARY	① ② ③ ④ Painful urination	① ② ③ ④ Ear aches	<input type="radio"/> yes <input type="radio"/> no Low back pain
	① ② ③ ④ Incontinence	<input type="radio"/> yes <input type="radio"/> no Hearing impairment	<input type="radio"/> yes <input type="radio"/> no Knee problems
	① ② ③ ④ Difficulty with urination	<input type="radio"/> yes <input type="radio"/> no Kidney stones	<input type="radio"/> yes <input type="radio"/> no Other: _____
	① ② ③ ④ Ringing in ears	<input type="radio"/> yes <input type="radio"/> no Kidney infections	
NERVOUS SYSTEM	<input type="radio"/> yes <input type="radio"/> no Dyslexia	<input type="radio"/> yes <input type="radio"/> no Epilepsy	<input type="radio"/> yes <input type="radio"/> no Developmental or growth problems
	<input type="radio"/> yes <input type="radio"/> no Learning disorder	<input type="radio"/> yes <input type="radio"/> no Head injury	<input type="radio"/> yes <input type="radio"/> no Nervous disorder? Type: _____
	<input type="radio"/> yes <input type="radio"/> no Multiple Sclerosis	<input type="radio"/> yes <input type="radio"/> no Numbness, Where? _____	
	<input type="radio"/> yes <input type="radio"/> no Muscular dystrophy	<input type="radio"/> yes <input type="radio"/> no Tingling, Where? _____	
MUSCLES / JOINTS	① ② ③ ④ TMJ pain	① ② ③ ④ Arm Weakness	<input type="radio"/> yes <input type="radio"/> no Rheumatoid Arthritis
	① ② ③ ④ Facial pain	① ② ③ ④ Trunk Weakness	<input type="radio"/> yes <input type="radio"/> no Artificial joints
	① ② ③ ④ Loss of Balance	① ② ③ ④ Difficulty walking	<input type="radio"/> yes <input type="radio"/> no Broken bones, fractures? _____
	① ② ③ ④ Poor coordination	① ② ③ ④ Joint swelling	
	① ② ③ ④ Leg Weakness	<input type="radio"/> yes <input type="radio"/> no Osteoarthritis	<input type="radio"/> yes <input type="radio"/> no Pins, etc? _____

MUSCLES / JOINTS (cont)

Mark the circle of painful areas, and indicate on which side: (R) right and / or (L) left

<input type="radio"/> yes <input type="radio"/> no	Shoulder	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Legs	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Mid back	<input type="radio"/> R <input type="radio"/> L
<input type="radio"/> yes <input type="radio"/> no	Arm	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Knee	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Low back	<input type="radio"/> R <input type="radio"/> L
<input type="radio"/> yes <input type="radio"/> no	Elbow	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Foot	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Limited movement? Where? _____	
<input type="radio"/> yes <input type="radio"/> no	Hands	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Neck	<input type="radio"/> R <input type="radio"/> L		_____	
<input type="radio"/> yes <input type="radio"/> no	Hip	<input type="radio"/> R <input type="radio"/> L	<input type="radio"/> yes <input type="radio"/> no	Upper back	<input type="radio"/> R <input type="radio"/> L		_____	

OTHER

<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Insomnia	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Fatigue	<input type="radio"/> yes <input type="radio"/> no	Weight loss
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Depression	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Difficulty with speech	<input type="radio"/> yes <input type="radio"/> no	Tuberculosis
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Sleep too much, how long?	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	No thirst	<input type="radio"/> yes <input type="radio"/> no	Thyroid problems
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Shaky	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Excessive thirst	<input type="radio"/> yes <input type="radio"/> no	Fibromyalgia
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Poor memory	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Dry mouth	<input type="radio"/> yes <input type="radio"/> no	Poor sense of smell
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Difficulty paying attention	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Pain at night	<input type="radio"/> yes <input type="radio"/> no	Poor sense of taste
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Anxiety	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Headaches	<input type="radio"/> yes <input type="radio"/> no	Cancer, Where? _____
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Easily angered	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Migraines	<input type="radio"/> yes <input type="radio"/> no	Allergies? List: _____
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Obsessive tendencies in work relationships	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Eye pain		_____
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Difficulty making plans or decisions	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Dry eyes	<input type="radio"/> yes <input type="radio"/> no	Hepatitis? type: _____
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Dizziness	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Watery eyes	<input type="radio"/> yes <input type="radio"/> no	Infectious disease: _____
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Soft or brittle nails	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Other eye problems? _____	<input type="radio"/> yes <input type="radio"/> no	Herpes
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Intolerance to temperature / weather changes	<input type="radio"/> yes <input type="radio"/> no	Dental problems	<input type="radio"/> yes <input type="radio"/> no	Candida
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Fever	<input type="radio"/> yes <input type="radio"/> no	Poor hearing	<input type="radio"/> yes <input type="radio"/> no	Shingles
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Chills	<input type="radio"/> yes <input type="radio"/> no	Difficulty swallowing	<input type="radio"/> yes <input type="radio"/> no	Chemical dependency _____
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Nose bleeds	<input type="radio"/> yes <input type="radio"/> no	Diabetes		_____
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Swollen glands	<input type="radio"/> yes <input type="radio"/> no	Weight gain	<input type="radio"/> yes <input type="radio"/> no	Skin condition: _____

MEN ONLY

<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Prostate problems	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Impotence	<input type="radio"/> yes <input type="radio"/> no	Infertility
<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Pain associated with genitals	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Problems urinating	<input type="radio"/> yes <input type="radio"/> no	Prostate cancer

WOMEN ONLY

<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	Breast pain or tenderness	<input type="radio"/> yes <input type="radio"/> no	Menopausal symptoms: _____	<input type="radio"/> yes <input type="radio"/> no	Ovarian cysts
<input type="radio"/> yes <input type="radio"/> no	Breast lumps	<input type="radio"/> yes <input type="radio"/> no	Are your cycles regular? Length of cycle: _____	<input type="radio"/> yes <input type="radio"/> no	Endometriosis
<input type="radio"/> yes <input type="radio"/> no	Nipple discharge	<input type="radio"/> yes <input type="radio"/> no	Painful menses with heavy or excessive flow	<input type="radio"/> yes <input type="radio"/> no	PMS
<input type="radio"/> yes <input type="radio"/> no	Menopause	<input type="radio"/> yes <input type="radio"/> no	Painful intercourse	<input type="radio"/> yes <input type="radio"/> no	Infertility

WELL BEING

* 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					
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: \_\_\_\_\_

**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

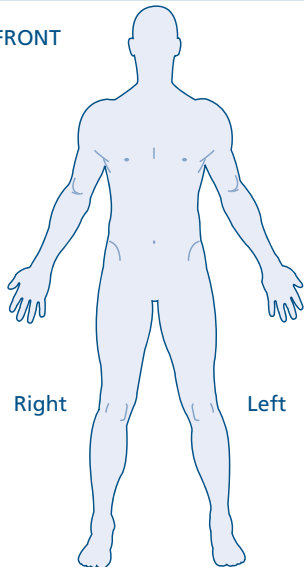
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

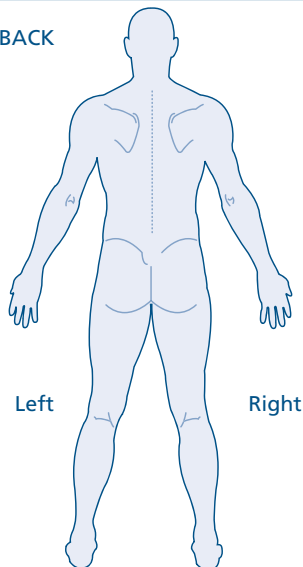
**PART 4.**

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

FRONT



BACK



COMMENTS:

\_\_\_\_\_

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\_\_\_\_\_

Practitioner's comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client signature: \_\_\_\_\_

Date: \_\_\_\_\_

Practitioner signature: \_\_\_\_\_

Date: \_\_\_\_\_