# HEALTH QUESTIONNAIRE

Name: _____ DOB: _____

Email Address: _____

Phone Number: _____

Address: _____

**About your health:**

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. Please complete this case history to help uncover the layers of damage.

Please circle **Yes / No** where applicable and **Explain** where necessary:

Did you have a difficult birth ◯ Yes / ◯ No _____
Did you roll out of bed or have any falls as a child? ◯ Yes / ◯ No _____

Did you / Do you smoke? ☐ Never ☐ Reformed Smoker ☐ Daily
Do you / Did you drink Alcohol? ☐ Never ☐ Did Previously How Often_____
Did you /Do you take drugs? ☐ Never ☐ Did Previously How Often_____
If recent or current, please list medications: _____

Do you eat healthy? ☐ Yes ☐ No ☐ I try to eat healthy
Have you been in any accidents? Yes / No Specify_____
Have you had any surgeries? Yes / No Specify_____

Sleeping Posture: (please tick) ☐ Side ☐ Stomach ☐ Back

Did you/ Do you have
Physical / Mental Stress? ◯ Yes/ ◯ No _____
Sports Injuries? ◯ Yes/ ◯ No _____
Other Traumas/Abuse? ◯ Yes/ ◯ No _____

Any other symptoms you are experiencing: (please tick)

| | | | | | |
|---|---|---|---|---|---|
| Neck Pain | ☐ | Numbness in Fingers | ☐ | Nervousness | ☐ |
| Stiff Neck | ☐ | Shoulder Pain | ☐ | Tension & Irritability | ☐ |
| Headaches | ☐ | Cold Feet | ☐ | Fatigue | ☐ |
| Dizziness | ☐ | Loss of Smell/Taste | ☐ | Depression | ☐ |
| Fainting | ☐ | Cold/Flu | ☐ | Chronic Fatigue | ☐ |
| Ears Ringing | ☐ | Allergies | ☐ | Pins/Needles | ☐ |
| Balance Loss | ☐ | Pain in Mid-Spine | ☐ | Shortness of Breath | ☐ |
| Numb Toes | ☐ | Cold Sweat | ☐ | Weight Problems | ☐ |
| Chest Pain | ☐ | Hearing Problems | ☐ | Stomach/Digestive Issues | ☐ |
| Fever | ☐ | Lights Bother Eyes | ☐ | Constipation/Diarrhea | ☐ |
| Menstrual Pain | ☐ | Pins/Needles in Arms | ☐ | Loss of Memory | ☐ |
| Migraines | ☐ | Stress | ☐ | Difficulty Breathing | ☐ |
| Thyroid Issues | ☐ | Not Sleeping | ☐ | Lower Back Pain | ☐ |
| Sciatica | ☐ | Fibromyalgia | ☐ | Knee Pain | ☐ |

## HEALTH QUESTIONNAIRE

What is your body telling you right now? What symptoms are you experiencing?

_____

_____

_____

What do you think the cause is?

_____

_____

What makes your condition better or worse?

_____

_____

Is this condition interfering with: Work☐ Sleep☐ Routine☐ Other☐

How can we assist you and help you the most? Any additional information to share?

_____

_____

_____

_____,

By signing this form, I agree and consent to the healing work.

I understand that with any healing process and work done on my body, my symptoms may worsen before they get better.

I understand this care is designed to assist the body with healing by helping to remove stressors from the body. I understand that healing takes time and there is no quick immediate fix to my problem, and health is a process.

I have freely decided to undergo the recommended treatment and hereby give me full consent to treatment.

Client Name: _____

Signature of Client: _____ Date: _____