AQUARIAN HEALING ARTS

CLIENT INFORMATION AND HEALTH HISTORY FORM

Name:_____ Date:_____

Home phone:_____ Cell phone:_____

E-mail address: _____

Address:_____City:_____State:_____ZIP:_____

DOB:_____ Sex:_____ Height: _____ Weight: _____

Single____ Married____ Divorced____ Widow____ In a relationship____

In case of an emergency who should I contact?

Name:_____Phone:_____

Relationship to you:_____

Are you pregnant?_____ When are you due?_____

No. of children and ages:_____

Occupation:_____ Do you like your job?_____

Were you ever vaccinated?_____

Do you have a regular bowel movement before noon each day?_____

Do you have two or more per day?_____Constipation:_____ Diarrhea:_____

Do you feel rested?_____ How much sleep do you get per night?_____

What time do you normally go to bed?_____

Do you wake up in the night? _____ What time? _____ How often?_____

Do you feel you wake up to go to the bathroom?_____

Do you feel stressed?_____ What causes most of your stress?

_____

What do you do when you are stressed?_____

Do you feel you have an outlet or a way to relieve stress and what is it?

_____

Describe your energy level: _____

What time of day do you feel your best?_____ Your worst?_____

Do you exercise? How often and what form of exercise?

_____

Are you currently seeing a medical doctor, naturopathic doctor, acupuncturist, or chiropractor for any reason? _____

Do you have any known food allergies or intolerances (shellfish, peanuts, gluten, dairy, etc.)?

_____

Please list surgeries:

_____

Are you currently taking any medication[please include birth control (pills)]?

_____

Please list five major health concerns that you have in <u>your_order of importance</u>.

1. _____

2._____

3._____

4._____

5._____

Please check all the symptoms that apply.

Acne	Alcoholism
ADD/ADHD	Allergies
Adrenal glands	Alternating anxiety/depression
AIDS/HIV	Anemia

Anger

Anxiety

Appendicitis

Arteriosclerosis

Asthma

Back pain

Bladder

Boils

Bones

Breathing problems

Bursitis/joint issues

Cancer

Candida

Carpal Tunnel Syndrome

Cataracts

Chest congestion

Chronic Fatigue Syndrome

Clicking in the jaw

Cold hands and feet

Colitis

Constipation

Crave carbohydrates: sweets, breads, and starches

Crave fat: ice cream, fried food, and potato chips

Crave protein: red meats, chicken, eggs, cheeses, and milk

Crohn's Disease

Depression

Diabetes

Difficulty concentrating/foggy headed

Difficulty getting going in the mornings

Digestive problems

Diverticulitis

Diverticulosis

Dizzy spells

Dry mouth

Ears ringing

Eczema

Edema

Emphysema

Epilepsy

Fibrocystic Breast Disease

Fibromyalgia

Fluid retention

Gallbladder

Gas

Goiter

Gout

Hair issues

Headaches/migraines

Heart disease

Heart issues

Heartburn

Hemorrhoids

Herpes

High blood pressure

High cholesterol

Hormones

Hyperthyroid

Hypoglycemia

Hypothyroid

Incontinence

Indigestion

Influenza

Insomnia

Joint aches

Kidney problems

Liver

Low blood pressure

Lupus

Lyme Disease

Lymph glands

Measles

Mucus

Multiple Sclerosis

Mumps

Nervous tension

Neuralgia

Numbness

Parasites

Parkinson's Disease

Pleurisy

Pneumonia

Polio

Psoriasis

Restless legs

Restlessness at night

Rheumatic fever

Rheumatoid arthritis

Scarlet fever

Soreness in upper shoulders (trapezius)

Stroke

Sweats

Tuberculosis

Tumors

Ulcers

Varicose veins

Venereal Disease

Vertigo

Very wet mouth

Weight-overweight

Weight-underweight

Whooping Cough

Yeast infections

Other:

Seizures

Shingles

Sinus

Skin problems

Sore jaw muscle

For Women Only:

High blood pressure

Hot flashes

Infertility

Menopause

Menstrual cramps

Miscarriage

Mood swings

Premenstrual Syndrome

Food and Beverage Consumption:

List the three worst foods you eat during the average week:

1. _____

2._____

3._____

List the three healthiest foods you eat during the average week:

1._____

2._____

3._____

Do you smoke?_____ Times per day/week:_____

Approximately how much water do you drink daily? _____

Distilled_____ Reverse osmosis_____ Spring_____ Tap_____

How many of these beverages do you consume per day?

Coffee_____ Green tea____ Black tea____ Soda____ Sweet tea____

Energy drinks_____ Bottled juice____

Do you use a juicer? _____ How many times per week?_____

How many alcoholic beverages do you consume per week? ____

Please list any natural supplements you currently take and for what reason:

Where did you hear about Aquarian Healing Arts?_____

Please take the time to use the back of this page to tell me whatever you think will help me to understand where you are in your pursuit of wellness.