

# Health And Well Being History Form

Name:

Address:

Home Phone:

Cellular Phone:

Date:

## 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:

\* 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	_____:	<input type="radio"/> None	<input type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
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 2.**

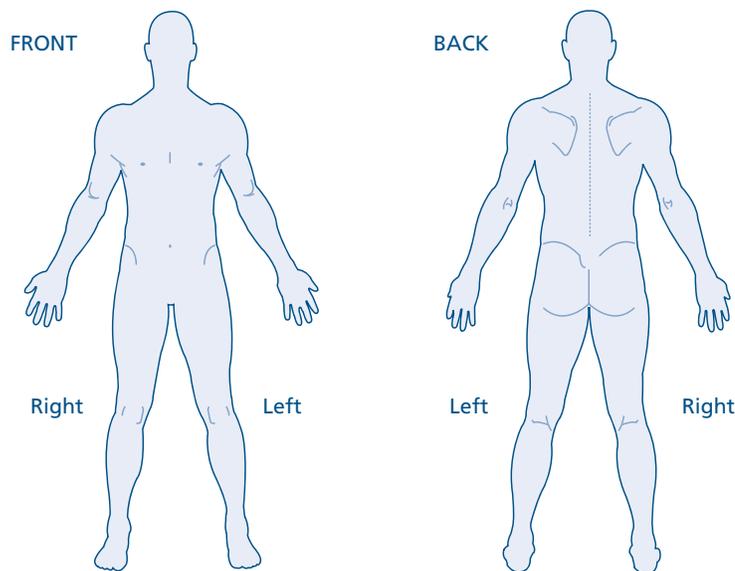
\* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.

- 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

**PART 3.**

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



COMMENTS:

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

Practitioner's comments:

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