

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:

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* Please circle any of the following feelings you have experienced in the last few months. <table border="0"> <tr> <td>Abused</td> <td>Paranoid</td> <td>Unable to grieve</td> <td>Panic</td> </tr> <tr> <td>Criticized</td> <td>Overwhelmed</td> <td>Apprehensive</td> <td>Intolerant</td> </tr> <tr> <td>Overworked</td> <td>Muddled</td> <td>Agitated</td> <td>Uncertainty</td> </tr> <tr> <td>Paralyzed</td> <td>Persecuted</td> <td>Uneasy</td> <td>Aggravated</td> </tr> <tr> <td>Depressed</td> <td>Guilty</td> <td>Distress</td> <td>Annoyed</td> </tr> <tr> <td>Rejected</td> <td>Easily irritated</td> <td>Fearful</td> <td>Angry</td> </tr> <tr> <td>Despair</td> <td>Anxious</td> <td>Impatient</td> <td>Outraged</td> </tr> <tr> <td>Helpless</td> <td>Sad</td> <td>Intimidated</td> <td>Nervous</td> </tr> <tr> <td>Hopeless</td> <td>Grieving</td> <td>Restless</td> <td>Worried</td> </tr> </table>	Abused	Paranoid	Unable to grieve	Panic	Criticized	Overwhelmed	Apprehensive	Intolerant	Overworked	Muddled	Agitated	Uncertainty	Paralyzed	Persecuted	Uneasy	Aggravated	Depressed	Guilty	Distress	Annoyed	Rejected	Easily irritated	Fearful	Angry	Despair	Anxious	Impatient	Outraged	Helpless	Sad	Intimidated	Nervous	Hopeless	Grieving	Restless	Worried	* Please mark the circle that best describes the level of stress for the below listings. My family stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe My relationship stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe My work stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe My financial stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe My health stress is: ☐ None ☐ Minimal ☐ Moderate ☐ Severe Other stress is _____: ☐ None ☐ Minimal ☐ Moderate ☐ Severe
Abused	Paranoid	Unable to grieve	Panic																																		
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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: _____

* 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 ⑦ 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

* 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:

Client signature:

Practitioner's comments: