Registration and Health History Form

Name Prefer to be called

Mailing address

Telephone

Email Date of birth Age

Occupation [or former occupation, if retired]

How did you find out about me?

Please tell me about the issues you want to address in our healing work together.
e.g. Physical - Mental/Emotional - Spiritual - Relational - Lifestyle - Life transition time

1]

2]

3]

4]

5]

Do you have any problems with any of the following, and if so, please explain:

Sleep [falling asleep or staying asleep?]

Appetite [poor, good, nausea?]

Digestion [heartburn? reflux? bloating?]

Bowels [tend toward constipation or loose?]

Urination [too frequent, urgent or infrequent?]

What do you drink during the day? Coffee, tea, water, alcohol, etc

What's your body temperature [do you tend cold or warm?]

Please list the surgeries you have had

Please list the major illnesses you have had or currently have

Please list any other hospitalizations

Please list any medications/supplements you take

If you are female, please describe your menstrual history.

_____ still menstruating _____ menopausal _____post-menopausal

If still menstruating, are your periods regular? Approximately how many days of flow?

Is your flow heavy or light? Are there clots in the blood?

Do you have pain with your period? PMS symptoms

Pregnancies? Do you have children, and if so, what are their ages?

Do you exercise, and if so, what kind and how often?

Do you smoke cigarettes or do recreational drugs?

Do you drink alcohol, and if so, what kind and how often/how much?

Do you have high blood pressure?

Signature _____ Date _____