HEALTH QUESTIONNAIRE

Name			DOB	
Address				
	State		Zip Code	
Telephone		Email		-
How did you	here about this?			

About Your Health:

The human body is designed to be healthy. Throughout life, events occur which damage your health. This case history will uncover the layers of damage, especially to the nervous system, which have resulted in poor health. Following your examination, your practitioner will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness (Birth-Age 5)

Let's begin at birth when you may have first damaged your nervous system, lost your wellness and began your journey to ill health.

Please tick Yes/No where applicable:

	Client Comments
Yes No	
	Yes No Yes No Yes No Yes No

Growth and Development		Client Comments
Did you roll out of bed as a child?	Yes No	
Childhood sicknesses?	Yes No	
Chair pulled out when you sat down?	Yes No	
Did you fall down stairs/fall from height?	Yes No	

Growth and Development		Client Comments	
Did you have other traumas? Yes		No	
What?			
When?			

Loss of Whole Body Health (age 5 – Present)

As you increase the layers of damage, you probably begin to experience symptoms and random bouts of sickness.

Question		Client Comments
Were you taught proper body movement and care?	Yes No	_
Did you/ Do you smoke?	Yes No	
Did you/ Do you drink alcohol?	Yes No	_
Diet – do you eat healthy?	Yes No	
Have you been in any accidents?	Yes No	
Specify:		
Have you had surgery and organs removed or replaced?	Yes No	_
Did you/ Do you take drugs?	Yes No	
Prescriptive or Non- prescriptive?	Yes No	
Teeth problems?	Yes No	_
Eye problems?	Yes No	
Hearing problems?	Yes No	
Exercise regularly?	Yes No	

Health Questionnaire

Question			Client Comments
Sleeping habits? (nightmares)	Yes	No	
Specify:			
Did you/ Do you have:			
Occupational stress?	Yes	No	
Physical and/or mental stress?	Yes	No	
Hobby/sports injuries?	Yes	No	
Other traumas or problems?	Yes	No	
Sleeping posture?	Yes	No	

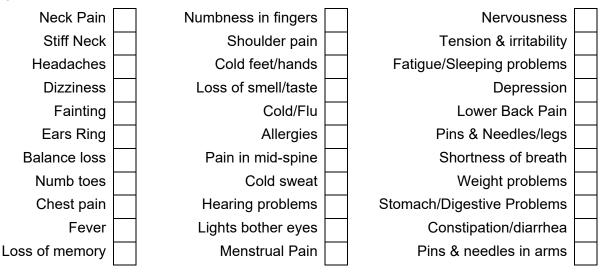
Present State of Health (Symptoms)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Major Complaint:	
Pain/Problem started when ?	
Pains are: Sharp	Dull Intermittent Is condition getting worse?
What activities aggravate your condition?	
What lessens your condition?	
Is this condition interfering with	Work Sleep Routine Other
Other doctors seen for this condition	
Any Home remedies:	

Health Questionnaire

Other symptoms (please tick if applicable):



Is there a family history of:

	Heart	Disease	Arthritis		Cancer		Diabetes		Other	
Father's Side	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Mother's Side	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

Check which of the following applies:

- 1. I have no special problems. I understand the role of Spinal Flow in my general health care.
- 2. I have a problem or symptom and I am interested in help with this specific problem. I am also interested in learning about my health and the role of Spinal Flow in improving the health of my family.
- 3. I have a problem or symptom and I am interested in help with this problem and in learning how to prevent it in the future.
- 4. I have a problem or symptom and I am interested in help with this specific problem.

About Your Care

Spinal Flow provides three types of care.

The aim of our health care is NOT to treat your symptoms, but to get to the cause of your problem and correct it properly. This is done through natural means, without the use of drugs or surgery.

Signature of Client:	