Health History

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you here/major symptom?

Any other Symptoms you are experiencing (Please tick if applicable)

Neck Pain \_\_\_ Reproductive Issues \_\_\_ Thyroid /Throat Issues \_\_\_\_

Headaches \_\_\_ Shoulder/Arm Pain \_\_\_ Sciatica \_\_\_\_

Stress \_\_\_ Pain in mid Spine \_\_\_ Lower Back Pain \_\_\_\_

Not Sleeping \_\_\_ Digestive Issues \_\_ Fibromyalgia/ chronic fatigue \_\_\_

Have you in the past or present Smoked \_\_\_\_\_\_

Have you in the past or present consumed Alcohol \_\_\_\_\_\_

Have you had any past or present Physical Stress or had any Past Surgeries?

Have you had any past or present Chemical Stress or taking any Medication Now?

Have you had any past or present Emotional Stress or Trauma?

On the scale 0 -10 how much stress is in your current life

0 = no stress 10 = Extreme Stress 0 1 2 3 4 5 6 7 8 9 10

On the scale 0 - 10 how much Trauma is in your life?

0 = No Trauma 10 = Extreme Trauma 0 1 2 3 4 5 6 7 8 9 10

On the scale 0 - 10 how happy are you?

0 = Unhappy 10 = Ecstatic 0 1 2 3 4 5 6 7 8 9 10