103 E. Glade Lane
Payson, AZ 85541
928-468-5800

Our office recognizes that every client has the Right of Privacy concerning their personal information. While we are not a medical facility we make every effort to protect and preserve client records in a manner that secures information and confidentiality. This Health History is the property of Quest For Wellness.

CLIENT HEALTH INFORMATION FORM

NAME:(Print)_____**BIRTHDATE:**_____

PLACE OF BIRTH_____ **U.S. CITIZEN?**_____**AGE:**_____

PHONE :(home)_____ **(cell)** _____**(work)**_____

MAILING & STREET ADDRESS: _____

CITY: _____**STATE:**_____**ZIP CODE:** _____

OCCUPATION: _____**EMPLOYER:**_____

BUSINESS NAME:_____**ADDRESS:**_____

CITY, STATE:_____**SPOUSE:**_____

SPOUSE PHONE or Relative:_____

MARITAL STATUS:_____**REFERRED BY:**_____

What do you wish to achieve by your visits to Quest For Wellness?_____

_____

_____

Are you willing to follow a program to accomplish this?_____

The time you last ate?_____ **What did you last eat and drink before arriving here?**

_____

Do you exercise daily?_____ **What form of exercises?**_____

How many bowel movements do you have a day?_____

Do you have dental fillings, what kind? _____

Do you currently have a viral or bacterial infection such as staph or other?_____

MEDICAL HISTORY AND ALTERNATIVE HEALTH HISTORY

Have you visited other Alternative or Natural Health Practitioners for current health concerns or past health imbalances? _____With what results? _____

_____

Are you currently on another Practitioners Nutritional Balancing Program? _____Are you currently taking Nutraceuticals or other Nutritional Products recommended by another Practitioner? _____

When did you last see them?_____

Please list all nutritional products currently taking:

(Including from Chiropractor, Health Food Store, or Self choice products, Cleanses, Hormone Creams or Homeopathy)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

For:_____

_____

_____

If you need more space to complete Nutritional products or Medications you are currently taking, record this on the back of last page.

List ALL prescription medications you are currently taking and what they are for:

Rx_____ **For:**_____

Rx_____ **For:** _____

Rx_____ **For:** _____

Rx _____ **For:** _____

Rx _____ **For:** _____

Rx _____ **For:** _____

Do any of these medications cause a reaction to foods, herbal tinctures or anything else you may come in contact with?_____ If so, list what substances may cause a reaction to what medication:

_____ _____

_____ _____

_____ _____

_____ _____

List ALL over-the –counter drugs: Include anything you take for sleeping, weight loss, pain and headaches etc.

OTC _____ **For:** _____

OTC _____ **For:** _____

OTC _____ **For:** _____

OTC _____ **For:** _____

Do you take Laxatives or natural products to have bowel movements? _____ **Have you taken any bowel cleansers in the last year and if so, what?** _____

_____

List ALL your known (and suspected) Allergies:

_____ _____

_____ _____

_____ _____

Are you allergic to any essential oils, herbal tinctures or ingredients in creams and lotions, anything else that is necessary for our staff and therapists to know to assist your therapies or services?

_____

_____

Have you ever been hospitalized due to diagnosed mental conditions, alcoholism, substance abuse or nervous breakdown?_____ **If so, state when, where, and the diagnosis of the conditions?** _____

_____

_____

Have you ever been admitted to a psychiatric institution?_____ **If yes, how long ago, and what was the therapy or drug therapy given?**_____

Are you a recovering alcoholic?_____

LIST SURGERIES/HOSPITILIZATIONS: Includes from childhood to now.

Date/Year	**Surgery**	**Illness/Accident**
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

If you are female is there a possibility that you are now pregnant?_____

What do you eat and drink?

Is this important for us to know? Yes, have you heard the saying you are what you eat? It is true, and you are what you absorb. Did you also know that what you eat may be making you sick?

Do you consume?	Daily	Weekly	Occasionally
Soda			
Diet Soda			
Splenda/sweeteners			
Refined carbs(breads, donuts)			
Sugars and desserts			
Wheat products			
Soy products			
Dairy products			
Pizza/Pastas			
Sandwiches			
Condiments (mustard, vinegar, mayo)			
Alcohol/What kind?			
Caffeine/What kind?			
Vegetables			

How many meals do you eat out? _____

Where do you frequently eat? _____

What do you use for sandwiches? _____

What kind of water do you drink, and how much? _____

What forms of carbohydrates do you frequently eat such as bread, donuts, pastas, cakes and others not listed; please describe: _____

What do you usually have for breakfast (please describe food choices and beverages): _____

_____

_____

_____

What do you usually have for lunch:_____

_____

_____

_____

What have you had for dinner in the last week to two weeks? _____

_____

_____

_____

_____

Snacks? _____

_____

Do you crave any foods?_____**If so please describe:** _____

_____

Do you eat organic foods?_____**If so how much and what?**_____

_____

Please check the box and circle any of the following you have had, been diagnosed with, or are experiencing. Please put a "P" to the side for past, and a "C" to side for current symptoms.

- ☐ Blood Transfusion
- ☐ Colonoscopy
- ☐ Sigmoidoscopy
- ☐ Laparoscopy
- ☐ Lower/Upper GI
- ☐ Epidurals
- ☐ Spinal /Disc Procedure
- ☐ Implants, breast, other
- ☐ Chemo/Radiation
- ☐ Cortisone Therapy
- ☐ Bowel Surgery
- ☐ Abortion
- ☐ Chicken Pox
- ☐ Measles
- ☐ Small Pox
- ☐ Tuberculosis
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Whooping Couch
- ☐ Typhoid Fever
- ☐ Diphtheria
- ☐ Valley Fever
- ☐ Rheumatic Fever
- ☐ Hepatitis _____?
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Reflex Sympathetic Dystrophy (RSDS)
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Disc Herniated/Bulging
- ☐ Lymphedema
- ☐ Lupus
- ☐ Gout
- ☐ Arthritis
- ☐ Degenerative Disease
- ☐ Autoimmune Disease

- ☐ High/Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Diagnosed Heart Disease
  _____
- ☐ Pacemaker
- ☐ Angina/Chest Pain
- ☐ Vascular Stent
- ☐ Irregular Heart Beats
- ☐ Stroke
- ☐ Aneurysm
- ☐ Varicose Veins
- ☐ Thrombosis
- ☐ Phlebitis
- ☐ Blood Clots
- ☐ Arteriosclerosis

- ☐ Diabetes
- ☐ Constipation/Diarrhea
- ☐ Alternating
- ☐ Poor Appetite
- ☐ Excessive hunger
- ☐ Belching or Gas
- ☐ Nausea or Vomiting
- ☐ Bloating
- ☐ Ulcers
- ☐ Hemorrhoids or Piles
- ☐ Rectal bleeding
- ☐ Diverticulosis/Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Colitis
- ☐ Celiac Sprue Disease
- ☐ Irritable Bowel -IBS
- ☐ Discomfort after meals
- ☐ Food Allergies
- ☐ Alcoholic
- ☐ Substance Abuse

- ☐ Dry Skin
- ☐ Skin Eruptions/Lesions
- ☐ Eczema/Psoriasis
- ☐ Hives/Rashes
- ☐ Sensitive Skin
- ☐ Itching/Crawling
- ☐ Acne
- ☐ Bruise easily
- ☐ Hair loss
- ☐ Loss of Pigmentation

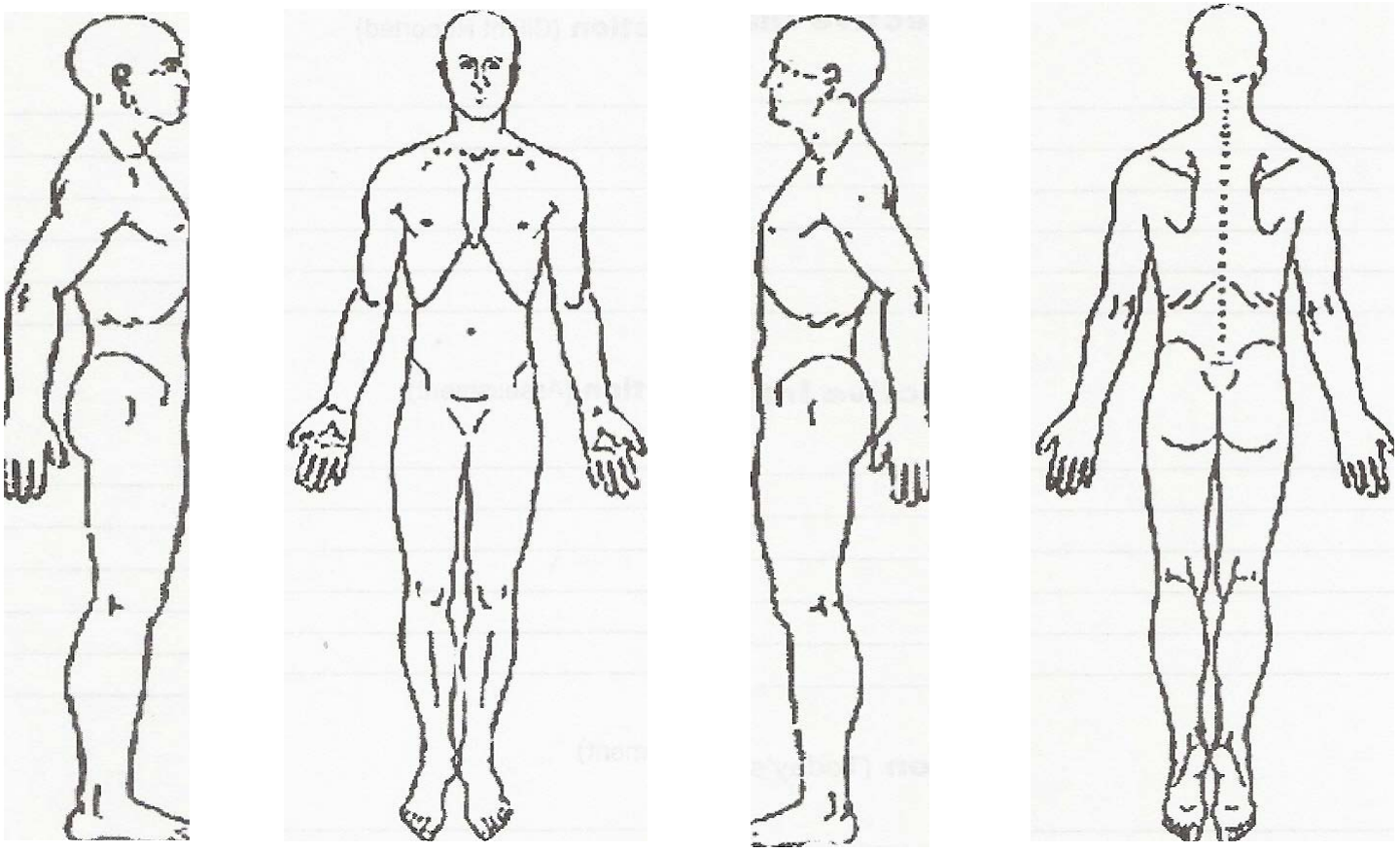
- ☐ Watery, itchy eyes
- ☐ Swollen, red, or sticky lids
- ☐ Glaucoma/ cataracts
- ☐ Blurred/Tunnel Vision
- ☐ Vertigo
- ☐ Meniere's Disease
- ☐ Nose bleeds/ Stuffy Nose
- ☐ Sinus Problems, Infection
- ☐ Hoarseness
- ☐ Faintness/Dizziness
- ☐ Hay Fever/Allergies
- ☐ Headaches
- ☐ Tinnitus/ringing in ears

- ☐ Asthma, Bronchitis
- ☐ Reoccurring Pneumonia
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ Other Respiratory
  _____
- ☐ Chemical Exposure
- ☐ Heavy Metal Exposure
- ☐ Environmental Illness
- ☐ Cigarette Smoking
- ☐ Smoke Other

- ☐ Poor Memory
- ☐ Confusion
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Multiple Personality
- ☐ ADD/ADHD
- ☐ Slurred Speech
- ☐ Mood Swings
- ☐ Anxiety, fear,
- ☐ Anger, Irritability
- ☐ Depression
- ☐ Learning Disability
- ☐ Epilepsy
- ☐ Brain Injury
- ☐ OCD

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Kidney Disease
  _____
- ☐ Incontinence
- ☐ Urinary Infections
- ☐ Interstitial Cystitis
- ☐ Genital Inflammation
- ☐ Discharge
- ☐ Irregular Menses
- ☐ Painful Menses
- ☐ Excessive Menses
- ☐ Scanty Menses
- ☐ Pregnancies_____
- ☐ Miscarriages _____
- ☐ Menopause
- ☐ Andropause
- ☐ Herpes
- ☐ STD/HIV
- ☐ Birth Control

Other_____
_____



Please mark any areas where you are experiencing or experience pain, stiffness, spasms, cramps, burning, tingling or numbness and injuries.

Please explain below and list in order of importance:

_____
_____
_____
_____
_____

*On a scale of 1 to 10 please rate your discomfort level, 10 being the worst.*_____

What are your goals in this assessment and or bodywork _____
_____
_____
_____

Authorization for the use of Photographs

In the event of conditions that require documentation for beginning evaluation and improvement as a result of therapy; i.e. Lymphedema, injuries, wounds, venous conditions

I HEREBY authorize Quest For Wellness Therapists to make and use any photographs for documentation of change, that may be used in educational presentations of such documented change. This authorization extends to copies of any said photographs, camera video clips. or PowerPoint for educational facilities, while keeping privacy intact. (Such as Lymphedema, injuries, wounds, venous conditions etc.)

DATE:_____

CLIENT SIGNATURE_____

CLIENT PRINTED NAME_____

WITNESS SIGNATURE: _____

WITNESS PRINTED NAME: _____

NUTRITIONAL STATEMENT OF INFORMED CONSENT

I hereby attest to the following:

1. I fully understand that Quest For Wellness office staff are not medical doctors, medical practitioners, or a medical clinic; they do not diagnose or treat disease; that I am not here for medical diagnostic or treatment procedures. I am over the age of eighteen and of sound mind and legally competent to sign this consent form.

2. The services performed by Quest For Wellness staff, whether in person, by mail, or by phone, are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of my nutritional health and do not involve diagnosing, treating or prescribing for the treatment of any disease. Quest For Wellness staff have made no claims of cures or treatment concerning any specific disease of affliction I might have, and I fully understand that they will not treat or cure any particular affliction.

3. If a physician refers me to Quest For Wellness staff for nutritional counseling/balancing, I fully understand that it is my Physician who is treating me, and not the Quest For Wellness staff. that My personal Physician, _____, is licensed to practice medicine in the state of _____.

4. Quest For Wellness staff has not, and will not, suggest that I cease current medical care I am receiving, be it drug therapy, X-Ray, Chemotherapy, surgery, or any other medical procedures which my medical Doctor deems necessary for my health and well-being. If I choose not to follow any of the recommendation made by my Medical Doctor, I understand that such decision is totally my responsibility, made entirely of my own consequences of such a decision.

5. I affirm that I am here on this or any subsequent visit solely on my own behalf, or I am a parent on behalf of a minor.

FINANCIAL AND INSURANCE POLICY
Insurance Claims

I hereby acknowledge the following:

I understand that Quest For Wellness is not a medical facility and operates on a cash basis, this means full payment is due at the time of services and purchases. QFW is not an Insurance Provider; does not accept or assist with other sources of "financial aid" payment programs, applications or correspondence for such. If I send claims to my insurance company for reimbursement or any other purpose requiring additional paperwork from Quest For Wellness, I *agree to disclose in writing before services and agree to prepay additional charges for the labor and paperwork involved.*

If your purpose is to obtain care for these reasons you must disclose your purpose on this page.

READ THIS CAREFULLY

I understand full payment is due at time of service, with a cancellation period of 24 hours. If I am appointing for or with a group of 2 or more persons, I must give 1 weeks' notice of cancellation, rather than 24 hours. Should I fail to give this notice for myself or my group, I *agree to pay the appointment fees or forfeit pre payments. I agree this conduct deprives the therapist and consultant of income.*

I understand my health history is to acquire necessary information for my benefit; and is applied to all the services rendered in this office. Failure to complete this history with true and accurate information may result in my receiving no benefit from Quest For Wellness services.

Upon seeking QFW assessment, services, products and education for nutritional and body balancing, I understand that I should not add other nutritional products to my QFW program without consulting with them first, and understand this may also result in my receiving no benefit from their services. I understand that QFW reserves the right to terminate any services should they feel I would be better served elsewhere.
Returns and Refunds: All sales are final.

Note: Bodywork cannot be given while you have a fever, flu, staph, MRSA and other infections.

***Welcome* and *Thank you* for your cooperation in your quest for wellness.**

I hereby attest that I have completed the Health History form in its entirety, and read the NUTRITIONAL CONSENT, PHOTO CONSENT, FINANCIAL and INSURANCE POLICY and QFW Disclaimer and I agree to the terms therein.

Date:_____

Print Name: _____

Signature: _____

If minor, Child's Full Name_____ **Age:** _____

Signature of Parent consenting for minor_____

In case of emergency, Contact: _____**Phone:** _____