Erin Elizabeth Holistic Health

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TO BE COMPLETED AT LEAST ONE WEEK BEFORE YOUR APPOINTMENT:

The following information is required for your safety, and to benefit your health and welfare. The following details will be treated with the strictest confidence. Your answers will help me get an accurate history of your medical concerns and conditions.
Please fill in all of the pages, it is long because it is comprehensive. I really want to know you well so I can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, leave it blank. Thank you!

Full Name:_____Date of Birth:____/____/____Sex:_____

Address:_____

Email:_____Phone:_____

MEDICATIONS, VITAMINS OR REMEDIES YOU ARE CURRENTLY TAKING:

MEDICATION	DOSE	TIMES PER DAY

ALLERGIES OR INTOLERANCE TO MEDICATIONS OR REMEDIES?

HOW WOULD YOU RATE YOUR HEALTH? Excellent____Good____ Fair____ Poor____

Main Complaints in order of importance (listing as many details as possible, such as when you get symptoms, locations, severity, descriptive words of symptoms are very helpful):

Please describe your personality, personal preferences (hot/cold, morning/night), any strong likes/dislikes, emotions, fears, etc.

Are there any traumatic events (surgeries, drug reactions, life trauma) that you feel may have caused or contributed to your health problems?

What is your job? Do you enjoy it? How are the stress levels with your job?

Describe your family relationships and your home environment.

What do you do to relax or destress? Do you handle stress well?

Describe your typical eating habits for breakfast, lunch, dinner and snacks.

HAVE YOU EVER SUFFERED, FROM ANY OF THE FOLLOWING? PUT DATES IF AVAILABLE FOR PAST. PUT MOM, DAD, GP, GM, ETC. FOR FAMILY.

SKIN	**NOW**	**PAST**	**FAMILY**
DRY, ROUGH, SCALY, ITCHY			
RASHES			
MOLES/CYSTS			
LIGHT/DARK PATCHES			
ACNE			
LOSS OF HAIR			
HIVES			
LYMPHATIC/ IMMUNE SYSTEM			
PAINFUL LYMPH NODES			
BRUISE EASILY			
WOUNDS HEAL SLOWLY			
ANEMIA			
SWOLLEN GLANDS			
FLUID RETENTION			
ENDOCRINE			
UNEXPLAINED WEIGHT LOSS/GAIN			
PREFERS HOT WEATHER			
PREFERS COLD WEATHER			
HATE THE HEAT			
HATE THE COLD			
COLD HANDS AND FEET			
FATIGUE LONG TERM			
WEAKNESS			
INCREASED THIRST			
INCREASED HUNGER			

RESPIRATORY	NOW	PAST	FAMILY
UNEXPLAINED FEVER			
CHEST PAIN WHEN BREATHING			
WHEEZING			
DIFFICULTY BREATHING AT NIGHT			
CONGESTION			
SHORTNESS OF BREATH			
CARDIOVASCULAR			
CHEST PAIN WHEN WALKING			
CHEST PAIN WHEN SITTING/LYING			
SWELLING IN ANKLES OR ABDOMEN			
PALPITATIONS			
VARICOSE VEINS			
HEART DISEASE			
GASTROINTESTINAL			
CONSTIPATION			
DIARRHEA			
HEMORRHOIDS			
BLOOD IN STOOL			
# OF BOWEL MOVEMENTS PER DAY			
FREQUENT NAUSEA			
HEARTBURN			
TROUBLE SWALLOWING			
EXCESSIVE BELCHING			
BLOATING			
CRAMPING			
ANOREXIA			
BULIMIA			
ABDOMINAL PAIN			

GASTROINTESTINAL CONT.	NOW	PAST	FAMILY
DISTRESS FROM GREASY FOOD			
BAD BREATH			
INDIGESTION			
CRAVING SWEETS			
CRAVING SALT			
BAD TASTE IN MOUTH			
OVERWEIGHT			
PARASITES			
JAUNDICE			
FEMALE REPRODUCTIVE			
PELVIC PAIN			
HEAVY MENSTRUATION			
MENOPAUSE			
TAKING BIRTH CONTROL			
PERIOD TIMING AND DURATION			
# OF PREGNANCIES, NATURAL OR C-SECTION			
PITUITARY			
FAILING MEMORY			
ABNORMAL THIRST			
ULCERS			
LOW BP			
THYROID			
OVERWEIGHT			
TIRED UPON RISING			
NERVOUSNESS			
THYROID DISEASE			
HYPOTHYROIDISM			
HYPERTHYROIDISM			

ADRENALS	NOW	PAST	FAMILY
EASILY STRESSED			
HOT FLASHES			
WEAK NAILS			
ARTHRITIS			
POOR CIRCULATION			
FACIAL HAIR IN WOMEN			
SYMPATHETIC NERVOUS SYSTEM			
DRY EYES, NOSE, MOUTH			
NERVOUSNESS			
DECREASED URINE OUTPUT			
HEART POUNDS WHEN LYING DOWN			
FREQUENT COLD SWEATS			
PARASYMPATHETIC NERVOUS SYSTEM			
JOINT STIFFNESS RISING			
MUSCLE CRAMPS			
BUTTERFLIES IN STOMACH			
LOW PERSPIRATION			
PROFUSE PERSPIRATION			
SLOW PULSE			
IRREGULAR BREATHING			
PUFFY EYES			
MUSCULOSKELETAL			
JOINT PAIN			
BACKACHES			
MENTAL			
ANXIETY			
EXCESSIVE WORRY			
DEPRESSION			

MENTAL CONT.	NOW	PAST	FAMILY
DISCONTENT/DISPAIR			
SUICIDAL THOUGHTS			
LONELINESS			
MOOD SWINGS			
PREFER TO BE WITH PEOPLE			
PREFER TO BE ALONE			
AFRAID			
CONFIDENT			
CONFUSION			
CONCENTRATION			
DIFFICULTIES SHY			
SELF-CRITICAL			
JEALOUS/SUSPICIOUS			
ORGANIZED			
AFFECTIONATE			
ASSERTIVE			
LIFESTYLE			
# OF CAFFEINATED BEVERAGES PER DAY			
# OF ALCOHOLIC BEVERAGES PER WEEK			
RECREATIONAL DRUG USE (LIST)			
# OF CIGARETTES PER DAY (SECONDHAND TOO)			
# OF SLEEP HOURS PER NIGHT			
TIME EXERCISING PER WEEK			
CHEMICAL EXPOSURE AT WORK			
# OF GLASSES OF WATER PER DAY			
DO YOU HAVE ENJOYABLE HOBBIES?			
DO YOU HAVE A STRONG SUPPORT SYSTEM?			
DO YOU HAVE A SPIRITUAL PRACTICE?			

DISEASES/CONDITIONS	NOW	PAST	FAMILY
HIGH CHOLESTEROL			
HEART ATTACK			
CORONARY ARTERY DISEASE			
DIABETIC			
CANCER, BREAST			
CANCER, COLON			
CANCER, PROSTATE			
CANCER, LIVER			
CANCER, INTESTINAL			
CANCER, UTERINE			
CANCER, LUNG			
CANCER, OTHER (LIST)			
OSTEOPOROSIS			
ALZHEIMER'S			
ASTHMA			
AUTOIMMUNE DISEASE			
BLOOD DISORDER			
EMPHYSEMA			
GENETIC DISORDER			
GLAUCOMA			
HEPATITIS B OR C			
KIDNEY STONES			
MACULAR DEGENERATION			
STROKE			
BONE FRACTURES			
SEIZURES			
SUDDEN CARDIAC DEATH			
SURGERIES			

I confirm that the information given above is correct and complete. I will inform my therapist of any medication, health, or diagnosed changes at any time during my treatment.

I understand that there shall be no liability on the therapist's part should I forget to do so. By signing this release, I hereby waive and release my therapist from all liability past, present, and future relating to my therapy treatments.

I understand that Erin Suttle is not licensed as a healthcare professional. She is not a doctor or physician. The state has not adopted any educational or training requirements for unlicensed complementary or alternative health care practitioners.

Erin cannot diagnose, cure, or treat diseases. Any advice given is for wellness and holistic lifestyle coaching only.

Signature_____ Date _____