HEALING WITH ANNA

Gentle touch, profound transformation

Health & Wellness Questionnaire

Name: _____

D.O.B: _____

Email Address: _____

Phone Number: _____

Welcome

Your body is naturally designed for health and vitality. Over time, life's stresses—especially those affecting your nervous system—can interrupt that balance. Together, we'll explore your story, gently uncover areas of strain, and begin restoring your body's innate healing potential.

Starting with You: How You're Feeling in This Moment

On a scale of 1–10, how would you currently rate the following? (1 = low, 10 = high)
If your score is less than 6, please tell us more.

Wellbeing Area	1–10	Notes if < 6
Happiness		
Confidence		
Anxiety		
Depression		
Worry		
Fear		
Negative self-talk		
Job Satisfaction		
Overall Life Fulfilment		
Stress		

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Early Life (Birth to Age 5)

Please circle **Yes/No** and add notes where helpful.

- Was the delivery long and/or difficult? Yes / No

  Notes: _____

- Were forceps or suction used? Yes / No

  Notes: _____

- Was it a Caesarean birth? Yes / No

  Notes: _____

- Breech/Cephalic presentation? Yes / No

  Notes: _____

Any known stress during pregnancy for mother/father?

Growth and Development

- Did you roll out of bed or have falls as a child? Yes / No
- Any childhood illnesses? Yes / No
- Other traumas (what/when)?

- Colic, reflux, or feeding difficulties?
  Yes / No

- Stressful events during early childhood?
  Yes / No

  Details:

Whole Body Health (Age 5 – Present)

- **Do/did you smoke?**
  ☐ Never ☐ Reformed smoker ☐ Daily: _____

- **Alcohol use:**
  ☐ Never ☐ Previously ☐ Weekly ☐ Daily: _____

- **Recreational drugs:**
  ☐ Never ☐ Previously ☐ Weekly ☐ Daily

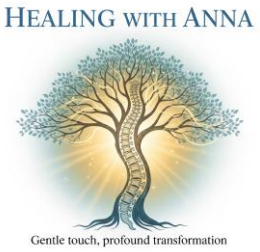
List type and last use:

- **Prescription or OTC medications:** ☐ Never ☐ Recently ☐ Currently:

  If yes, list meds and when last taken:

- **Will you continue taking medication during the retreat?**

☐ Yes ☐ No
(Please consult your doctor before stopping any medication.)



Diet & Lifestyle

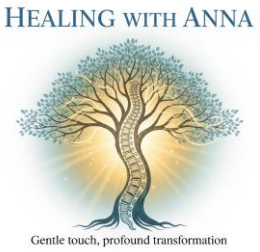
- Do you eat healthy? ☐ Yes, always ☐ I try ☐ Not really
- Describe your diet:

- Have you had surgery or organs removed/replaced? ☐ Yes ☐ No
- **Sleep:** Any issues with falling/staying asleep or waking up tired?

  Details:

- **Sleep position:** ☐ Side ☐ Stomach ☐ Back
- Occupational stress? ☐ Yes ☐ No
- Physical/mental stress? ☐ Yes ☐ No
- Sports/hobby injuries? ☐ Yes ☐ No
- Other traumas? ☐ Yes ☐ No

Any life events that affected your health and wellbeing?



Current Health & Symptoms

- What symptoms is your body experiencing right now?

- When did these symptoms begin?

- What do you believe caused them?

- What activities aggravate or relieve your symptoms?

Aggravate:

Relieve:

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- Are these issues interfering with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other:

- Are you missing out on anything you love because of this?

- If these symptoms disappeared tomorrow, what would be different in your life?

- Are you currently living the life you'd like to live?

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Additional Symptoms

Please tick all that apply:

☐ Neck pain
☐ Shoulder pain
☐ Headaches
☐ Stiff neck
☐ Sleep issues
☐ Tension/irritability
☐ Shortness of breath
☐ Digestive problems
☐ Knee pain
☐ Menstrual pain
☐ Fibromyalgia
☐ Numb fingers
☐ Dizziness
☐ Chronic fatigue
☐ Sciatica
☐ Constipation/Diarrhea
☐ Memory issues
☐ Stress
☐ Numb toes
☐ Cold hands/feet
☐ Depression
☐ Migraines
☐ Lower back pain
☐ Thyroid issues
☐ Weight challenges
☐ Ears ringing
☐ Vision/light sensitivity

Your Intentions

- What are you hoping to gain from these sessions?

- Have you experienced trauma or abuse in your life?

- How can we best support you in your healing journey?

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Consent

By signing this form, I willingly give my full consent to receive care. I understand that healing is a process that takes time, and that my symptoms may temporarily worsen before they begin to improve. I acknowledge that this approach is intended to support my body's natural ability to heal by relieving underlying stressors. I am choosing this path of care with the understanding that there is no instant fix, but rather a journey toward lasting wellness.

Client Name: _____

Signature: _____

Date: _____