Dr. Akmal at the Stretch Loft
4200 Forbes Blvd
Lanham, MD 20706
Phone 240-502-0449
Website: www. https://thestretchloft.com/

Personal Health History Intake Form

Date _____ Insurance I.D. Number _____

Patients Name _____

Patients Address _____ City _____ State _____

Zip Code_____ Phone home _____ Cell _____ Work _____

Email Address:_____

Patients Date of Birth _____ Place of Birth _____

Work/Occupation: _____

Name of Insured _____

Insureds Address if different _____ City _____ State _____

Phone Home _____ Cell_____ Work _____

Insurance Policy Group or FECA Number _____

Insured Date of Birth _____ Place of Birth _____

Employer's Name or School Name _____

Is there Another Health Name or Program Yes _____ No ____

I there Another Health Benefit Plan? _____

Patient's Relationship to Insured

Self ___ Spouse ___ Child ___ Other ___

Patient Status

Single ____ Married ___ Other ___

Employed ____ Full Time Student ___ Part-Time Student ___

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Personal Information:

Breast or bottle-feed (circle) Home or hospital birth (circle)

Approximate last date of medical exam? _____ First date of Complant _____

Are you presently under doctor's care? Yes ___ no ___

Name of Referring Physician or Other _____ Phone Number _____

Referring Provider's NPI number _____

Are you under the care of an Alternative Medical Professional yes no

If so please provide their information: _____

_____

Are you presently using any type of therapy? If yes please list

Please provide your health condition (s)?

Are you taking medication: yes no

If you are taking medication, please name the medication are you presently taking?

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Please list any herbs or other supplements you are presently taking?

What is your major concern today?

Female Disorders:

When was your last pap test?

Number of pregnancies: deliveries abortions miscarries other

Do you practice birth control yes no

What form of birth control do you use: pills ___rhythm ____ IUD ___ mucous method___ diaphragm condoms ___ spermicidal ___ Other ___

Date of last menstrual cycle? Are your cycles regular Yes ___ No ___

How many days is your cycle? Are they painful____ heavy ____ clotty _____ Other ___

Do you have soreness in your breast during your cycle? Yes ___ No ___

If so explain:

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Have you had a mammogram? Yes ___ No ___ If yes what was the results:

Has your breast leaked other than during the time you where breast-feeding? Yes No

If yes please explain:

Have you found any lumps in your breast? Yes ___ No ___ If so explain

Are you pregnant? Yes No if so how many months? _____

Male Health History:

Are you of the age to have a prostate exam? yes no if yes, when

What was the outcome of the exam?

Have you had any male fertility issues? yes no if yes, what

List your children:

Names	Sex	Birth date
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Past Medical History:

Do you have allergies? Yes ___ No ___

Which foods are you allergic to?

What is in your environment that could cause your allergies?

Do you take any regular medications, prescription, or over the counter for your allergies?

Have you had any operations? Yes ___ No ___ if yes then state when and for what illness.

Have you had any major injuries or accidents? Yes ___ No ___ if yes state what type of injury or accident.

Are you currently on medications? Yes ___ No ___

If the answer is yes, please list all medication.

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List any other health conditions you are experiencing.

What are your future goals for your health and well-being?

What are three factors in your life that seem most important to your daily health?

1.

2.

3.

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Are you interested in changing your health and life patterns? Yes ___ No ___

Explain how you would like to make this change.

Have you had a physical? Yes ___ No___ Date _____

Make one check mark on any of the symptoms or illness you have had. Make two check marks if the illness is recurring and make three if the illness is a regular difficulty.

weight loss or gain ____	high blood pressure _____	sores in mouth _____	diabetes _____
muscle cramps _____	kidney stone ____	joint swelling _____	headaches _____
pneumonia _____	psoriasis _____	elevated cholesterol ___	anemia _____
fever _____	dizziness _____	arthritis ____	obesity _____
ADD _____	hives _____	intestinal issues _____	polio _____
ringing in the ears ____	skin boils _____	constipation _____	nosebleeds ____
sinus congestion _____	allergies _____	diarrhea _____	colitis _____
jaundice _____	hepatitis _____	eye issues ____	syphilis _____
HIV _____	STDs _____	asthma _____	parasites _____
HPV _____	yeast infection _____	bruise easily _____	itching _____
fatigue ____	bad breath _____	teeth/gum issues ____	coughing ____
breathing difficulties ____	blackouts _____	muscle cramps/tension ____	hemorrhoids ____
heart palpitations ____	digestion issues ____	chicken pox ____	eczema ____

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epilepsy _____ aging rapidly ____ cancer ___
ulcers _____

sexual desire increase _____ or decrease _____ jaundice _____ mumps _____

substance abuse issues _____ poor endurance _____ chest pains _____ confusion _____

urinary tract issues burning _____ bubbly urine _____ bladder infection _____ bedwetting _____

blood in urine _____ lower back pain _____ mid back pain _____ neck pain _____

shoulder pain/tightness _____ leg pain/tightness _____ swelling of the ankles _____

low blood pressure _____ heart disease _____ heart attack _____ nervousness _____

Have you had any substance abuse issues? Yes ___ no ___

If yes please explain:

Do you smoke tobacco? Yes ___ No ___ if yes, when did you start _____

how much do you smoke a day? _____ Are you interested in quit smoking? yes no
if yes, when would you like to start? _____

Would you like assist to quit smoking? Yes ___ No ___

Have you been hospitalized for any major illness: Yes ___ No ___ If yes, please explain:

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Family History:

List immediate family members and their health status: If they are alive and well place A/W in the space and if they are deceased place D in the space.

Relationship	health status
Mother	_____
Father	_____
Sister	_____
Sister	_____
Sister	_____
Brother	_____
Brother	_____
Brother	_____

Are any of these following illnesses in your family tree?

mental illness _____ diabetes _____ cancer ____ high blood pressure _____

heart disease _____ thyroid issues _____ overweight/obesity _____

epilepsy _____ multiple sclerosis _____ tuberculosis _____ gout _____

Place write any other health information in this space that has not been covered above.

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Release Form

Healen Arts LLC is a Complementary Alternative Integrative Healthcare organization. We are not a substitute for your primary health care professional, physician, clinic, hospital, or any other health care provider or institution.

Dr. Muwwakkil nor staff have the authority to advise you to discontinue or change nor alter any prescribed medication that you are presently or recommended by your physician or health care provider.

Our services provide energy balancing methods that assists the body in regaining and maintaining its' own natural balance. We accomplish this through the use of Micronutrients, Phytonutrients, Bodywork Therapies, Visualization, Transpersonal and Spiritual Coaching. We make no claims to heal or cure any health imbalances.

By signing this form, release Healen Arts from any liability (ies) that may occur by any adverse effects from the therapies, supplements or service programs provided. In the event, you are using insurance coverage, this document permits Healen Arts to release medical information to your insurance company.

Date _____

Name: _____

Address _____

City _____ State _____ Zip _____

Phone number day _____ evening _____ cell _____

Email address _____

Signature _____

Signature of Insured card Holder if Different Then Above

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Name: Date: