

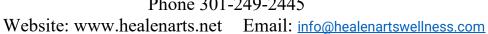


Website: www.healenarts.net Email: info@healenartswellness.com

#### Personal Health History Intake Form

Date Insurance	ce 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 V	Vork		
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-T	Cime Student		

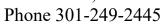
Phone 301-249-2445





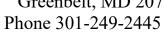
#### **Personal Information:**

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 yo	es please list
Please provide your health condition (s)?	
Are you taking medication: yes no	
If you are taking medication, please name the me	dication are you presently taking?



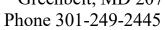


Please list any herbs or other supplements you are presently taking?					
What is your major concern today?					
Female Disorders:					
When was your last pap test?					
Number of pregnancies: deliveries	abortions	miscarries	other		
Do you practice birth control yes no					
What form of birth control do you use: pills _ condoms spermicidal Other	rhythm IUD	mucous method di	aphragm		
Date of last menstrual cycle?	Are your cycles reg	ular Yes	No		
How many days is your cycle?	Are they painful	heavy clotty	_Other		
Do you have soreness in your breast during you	r cycle? Yes _	No			
If so explain:					





Have you had a mammogram?	Yes	_ No_		If yes what was the i	results:	
Has your breast leaked other than durin	ng the tim	ie you v	where b	reast-feeding?	Yes I	No
Have you found any lumps in your brea	ıst?	Yes	-	No If so explain		
Are you pregnant? Yes No		if so h	ow man	y months?		
Male Health History:						
Are you of the age to have a prostate ex	am?	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 da	ate
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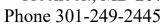


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Past Medical History:
Do you have allergies? Yes No
Which foods are you allergic to?
What is in your environment that could cause your allergies?
Do you take any regular medications, prescription, or over the counter for your allergies?
Have you had 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 injur or accident.
Are you currently on medications?  Yes No  If the answer is yes, please list all medication.



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?
What are three factors in your life that seem most important to your daily health?  1.
2.
3.





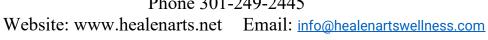
Are you interested in changing your health and life patterns? Yes No						
Explain how you would like to make this change.						
Have you had a physical?	Yes	No	Date			
Make one check mark on a illness is recurring and ma			s you have had. Make two ch ular difficulty.	eck marks if the		
weight loss or gain	high blood pre	essure	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	1	bruise easily	itching		
fatigue	bad breath		teeth/gum issues	coughing		
breathing difficulties	blackouts	_	muscle cramps/tension	_ hemorrhoids		
heart palpitations	digestion issue	es	chicken pox	eczema		



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aging rapidly cancer

epilepsy ulcers	aging rapidly	cancer	
sexual desire increase	or decrease	jaundice	mumps
substance abuse issues	_ poor endurance	_ chest pains	confusion
urinary tract issues burning	g 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 ankle	es
low blood pressure	heart disease	heart attack	nervousness
Have you had any substanc  If yes please explain:	e abuse issues?	Yes no	
how much do you smoke a		if yes, when did you ou interested in quit smoking	
Would you like assist to qui	it smoking? Yes	No	
Have you been hospitalized	l for any major illness:	Yes No If yes	s, please explain:

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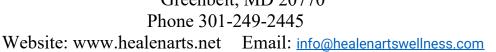
#### **Family History:**

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 i	llnesses in your fa	mily tree?			
mental illness	diabetes	cance	r	high blood p	ressure
heart disease	thyroid issues		overweight/o	obesity	-
epilepsy	multiple sclerosis	S	tuberculosis		gout

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

# Healen Arts Acupuncture Wellness Studio, LLC 7500 Greenway Center Drive - Suite 650 Greenbelt, MD 20770 Phone 301-249-2445





#### **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: