

Dr. Akmal Muwwakkil
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301-249-2445



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 Complaint _____

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 ___

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If so explain:

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.

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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?

1.

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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 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 ____

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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 _____
epilepsy _____	aging rapidly _____	cancer _____	ulcers _____

sexual desire increase _____ or decrease _____	jaundice _____	mumps _____
substance abuse issues _____	poor endurance _____	chest pains _____
urinary tract issues burning _____	bubbly urine _____	bladder infection _____
blood in urine _____	lower back pain _____	mid back 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 ___

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

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 _____

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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 _____

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Signature of Insured card Holder if Different Then Above

Name:

Date: