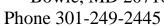






Personal Health History Intake Form

Date Insura	nce 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 B	irth	
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		





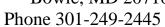


Personal Information:

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	10
Name of Referring Physician or Other	Phone Number
Referring Provider's NPI number	_
Are you under the care of an Alternative Medical Pr	rofessional 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 medi-	cation 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 dia	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 your	cycle? Yes _	No		
If so explain:				







Have you had a mammogram?	Yes	No_		If yes w	hat was the r	esults:	
Has your breast leaked other than d	uring the tim	e you w	vhere b	reast-fe	eding?	Yes	No
If yes please explain:							
Have you found any lumps in your b	reast?	Yes		No	If so explain		
Are you pregnant? Yes N	No	if so ho	ow man	y mont	hs?		
Male Health History:							
Are you of the age to have a prostate	e exam?	yes	no	if yes, v	vhen		
What was the outcome of the exam?							
Have you had any male fertility issue	es?	yes	no	if yes, v	vhat		
List your children:							
Names		Sex				Birth d	ate
							
				. <u></u>			
							
Past Medical History:							
Do you have allergies?	Ves 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.



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.
Are you interested in changing your health and life patterns? Yes No Explain how you would like to make this change.



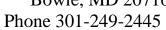
Have you had a physical?	Yes	No	Date	
Make one check mark on a illness is reoccurring and n	J 1		5	check marks if the
weight loss or gain	high blood pi	ressure	sores in mouth	diabetes
muscle cramps	kidney stone		joint swelling	headaches
pneumonia	psoriasis		elevated cholesterol	anemia
fever	dizziness		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	on	bruise easily	itching
fatigue	bad breath _		teeth/gum issues	coughing
breathing difficulties	blackouts		muscle cramps/tension	hemorrhoids
heart palpitations	digestion issu	ues	chicken pox	eczema
epilepsy	aging rapidly	·	cancer	ulcers
sexual desire increase	or decrease _		jaundice	mumps
substance abuse issues	noor e	endurance	chest pains	confusion

Phone 301-249-2445



	osite: www.healenarts.net		
blood in urine	lower back pain	mid back pain	neck pain
shoulder pain/tightness	leg pain/tightness _	swelling of the a	ankles
low blood pressure	heart disease	heart attack	nervousness
Have you had any substand If yes please explain:	ce abuse issues?	Yes no	
how much do you smoke a	Yes No day? Are y	ou interested in quit smo	
	ou like to start? it smoking? Yes		
Have you been hospitalized	d for any major illness:	Yes No I	f yes, please explain:
Family History:			
List immediate family men space and if they are decea	nbers and their health status sed place D in the space.	: If they are alive and we	ll place A/W in the
Relationship	health status		
Mother			
Father			

Website: www.healenarts.net Email: info@healen.net





Sister			
Sister			
Sister			
Brother			
Brother			
Brother			
Are any of these following i	llnesses in your fami	ly tree?	
mental illness	diabetes	cancer	high blood pressure
heart disease	thyroid issues	_ overweight,	obesity
epilepsy	multiple sclerosis _	tuberculosis	s gout

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

Website: www.healenarts.net Email: info@healen.net

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



Name:	Date: