

What is your primary health concern and how long have you had it? _____

If there was a medical diagnosis, please explain. _____

What are your recent medical procedures (x-rays, surgery, etc.) and the results? _____

Can you trace this health concern's origin? _____

What has been your treatment for it previously and did it help? _____

Other Health Concerns	Onset: month/year	Frequency	Severity

Family History

Please list age, any illness, or if deceased. If deceased, list the cause of death and age of death. Below you will find a list of possible illnesses. This is only a guideline and may not list the particular one your family member is associated with.

Allergies, Asthma, Bleeding Tendency, Cancer, Chron's Disease, Diabetes - age at onset, Drug Abuse, Epilepsy, Gall Bladder, Glaucoma, Heart Disease –Type, Hearing Loss, Hypoglycemia, Kidney Disease – Type, Liver Disease – Type, Lupus, Mental Illness – Type, Multiple Sclerosis, Rheumatoid Arthritis, Thyroid Disease, Tuberculosis, Skin Disease – Type, Other Conditions

Mother: _____

Father: _____

Brothers and Sisters: _____

Mother's Parents: _____

Father's Parents: _____

Children: _____

Please list any medications and the amount you are now taking:

Supplements and amount (vitamins, minerals, herbs, essential oils, homeopathics, etc.) _____

Any known allergies: _____

Any exposure to radiation, including dental x-rays: _____

Any major exposure to toxic chemicals: _____

Are you on any special diet? _____

Have you seen a naturopathic or holistic practitioner before? If yes, describe your experience. _____

What healing modalities have you tried? _____

What are your goals for this session? _____

What are your long term health goals? _____

Additional Comments:

Signature of Client: _____