

Client Health History

Name _____ Age _____ Sex _____ Height _____ Weight _____

Marital Status _____ Occupation _____

Address: _____ City _____ State _____ Zip _____

Email address: _____

Telephone Numbers: Home _____ Work _____

Emergency Contact: Name: _____ Phone Number: _____

How Did You Learn About Heartland Healing Alternatives, Ltd? _____

- List your top four current physical or emotional complaints in the order of their importance to you.
 - 1.
 - 2.
 - 3.
 - 4.
- List three health or lifestyle goals you would like to accomplish working with me (why are you here?)
 - 1.
 - 2.
 - 3.
- What will you do to ensure your success?

Do you have silver (mercury) fillings? If yes, how many _____ YES NO

Rate your level of emotional stress from 1-10 with 10 being the most.
How does this affect you? (1-10)
Describe the major stress factors in your life: _____

Please rate your current emotional health (please circle): Excellent Good Fair Poor Unstable Crisis

Are you currently in psychotherapy? Yes No Do you have a good support network / team? Yes No

Does your **home** environment have a supportive effect on your health? Yes Neutral No

Does your **work** environment have a supportive effect on your health? Yes Neutral No

How many hours of sleep do you get each night? _____ Do you wake rested? _____

Do you make an effort to eat organically grown foods? Yes No What % of your diet? _____

Are you on a restricted diet according to religious or other beliefs (e.g. Hindu, Kosher, Vegan, etc.)? Yes No

Are you considering any elective surgery or medical procedures in the near future? Yes No

If yes, please describe **what** you plan to have done and **why**. _____

How many times a week do you eat in a restaurant? Breakfast _____ Lunch _____ Dinner _____

What type of restaurants? _____

What are your **favorite** foods? _____

Do you crave sweets? _____ At what time of day _____ Do you salt the food at your table _____

What foods do you **really** dislike: _____

Are there any food your crave? (circle) Bread Pasta Dairy Meat Salty

Would you like to increase or decrease your weight? If so, by how much _____

When did you last have a significant (more than 10 pounds) change in weight? _____

What is your blood type? (circle one) A B AB O don't know

Number of alcoholic beverages consumed weekly? _____

Number of daily caffeinated beverages (include decaf coffee & tea)

Fish eaten per week (not canned or fried)

Times per week raw nuts/seeds eaten

Number of sodas consumed per week

Artificial sweeteners use

List foods or beverages consumed more than three times per week

How many times a week do your workout / exercise? _____ Is your exercise usually aerobic or anaerobic ? (circle)

Do you smoke?

Yes	No
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If yes, how many times per day?

Per week?

Please put a percentage next to the food groups that make up your overall diet

Fish

Chicken

Red Meat

Vegetables

Fruits

Fast Food

List the three worst foods you eat during an average week

List the three healthiest foods you eat during an avg. week

How many hours of relaxation (not including sleep) do you get weekly?

What are your favorite recreational activities

When was your last eye exam?

Do you wear contacts?

Circle disease for which you have been immunized:

Measles	Mumps	German Measles	Chicken Pox	Polio
Diphtheria	Hepatitis	Small Pox	Rubella	Other

Family Health History

Relation	Age	State of Health	Age at death	Cause of Death	Check if your blood relatives have/had:	
					Disease	Relation
Father					Arthritis	
					Gout	
Mother					Asthma, hay fever	
					Cancer	
					Chemical Dependency	
Brothers					Diabetes – Type I	
					Diabetes – Type II	
					Heart Disease, Stroke	
					Kidney Disease	
Sisters					High blood pressure	
					Syphilis, gonorrhea	
					Tuberculosis	
					Other	

List your past Serious Illnesses / Injuries / Surgeries	Date	Outcome

Do you have a pacemaker or any other implants? – If yes, please list YES NO

How was your health as a child? (circle one) excellent good fair poor

Were there any complications with your delivery? If yes, please explain _____

Were you breast fed? _____ For how long _____?

Did you have any serious emotional or mental trauma as a child? If yes, please explain _____

Women only (next two lines):

Age at onset of menstruation: _____ Number of children: _____

Number of miscarriages/c-sections _____ Age at onset of menopause: _____

List other health care practitioners you are seeing and their specialties _____

Please list any recent medical procedures or tests _____

✓ Allergies or Sensitivities (please specify)	Typical Reaction
<input type="checkbox"/> ANAPHYLAXIS?	_____
<input type="checkbox"/> Animal hair / dander	_____
<input type="checkbox"/> Chemicals	_____
<input type="checkbox"/> Drugs, medications	_____
<input type="checkbox"/> Dust, molds	_____
<input type="checkbox"/> Grasses, weeds, pollens	_____
<input type="checkbox"/> Eggs	_____
<input type="checkbox"/> Dairy	_____
<input type="checkbox"/> Fish/Shellfish	_____
<input type="checkbox"/> Peanuts	_____
<input type="checkbox"/> Corn	_____
<input type="checkbox"/> Wheat/Gluten	_____
<input type="checkbox"/> Food Additives	_____
<input type="checkbox"/> Food Coloring	_____
<input type="checkbox"/> Hair Coloring	_____
<input type="checkbox"/> Formaldehyde	_____
<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Perfumes	_____
<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Others:	_____

List all supplements / herbs / homeopathics you are currently taking:

Type (include brand name)	Purpose	Dosage

For all prescription and OTC drugs you are currently taking list frequency and purpose:

DRUG	FREQUENCY	PURPOSE
Antacids		
Antibiotics		
Antifungals		
Antihistamines		
Antidepressants		
Aspirin/Tylenol		
Anxiety Meds		
Cholesterol lowering meds		
Diuretics		
High Blood Pressure		
Hormone Replacement		
Hormone Creams		
Hydrocortizone Cream		
Laxatives		
Oral Contraceptives		
Pituitary		
Thyroid		
Other		

Describe a typical day's diet below (what you eat, time of day, portion sizes, include beverages)

Breakfast

Lunch

Dinner

Snacking habits

EXPOSURE RISKS - (0 = never, 1 = occasionally, 2 = regularly)

How often are strong chemicals used in your home? (Disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	0	1	2
How often are pesticides used in your home	0	1	2
Do you use lawn and or gardening chemicals (Roundup, weed-be-gone, fertilizers, etc.)			
How often do you have your home treated for insects	0	1	2
How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office	0	1	2
How often are you exposed to nail polish, perfume, air fresheners, hair spray or other cosmetics	0	1	2
How often are you exposed to diesel fumes, exhaust fumes or gasoline fumes	0	1	2
Of the food you eat, what percentage of it is "packaged"?			

Have you noticed any negative change in your health since you moved into your new apartment or home	Y	N
Have you noticed any negative change in your health since you started your new job?	Y	N
Do you have a water purification system in your home	Y	N
Do you drink bottled water	Y	N
Do you have indoor pets	Y	N
Do have an air purification system in your home	Y	N
Are you a dentist, farm worker, painter, printer, or construction worker?	Y	N

SYMPTOMS SURVEY FORM

Please mark your **current** level of symptoms with 1 being little discomfort and 10 being maximum discomfort. Leave line blank if no symptoms exist for that item

SYMPTOM	1	2	3	4	5	6	7	8	9	10
Abdominal bloating										
Acid Reflux										
Acne										
ADD/ADHD										
Anxiety										
Arthritis										
Asthma										
Autism										
Backache										
Bed Wetting										
Behavioral Problems										
Bipolar Disorders										
Blurred vision										
Brain Fog										
Cancer										
Chemical sensitivities										
Chicken Pox										
Constipation										
Depression										
Diarrhea										
Dizziness										
Dry Skin										
Ear Disorder										
Ear Infections										
Eczema										
Excessive Gas										
Excessive Perspiration										
Exercise Induced										
Eye Disorder (type)										
Fatigue Syndrome										
Fibromyalgia										
Frequent Urination										
General Fatigue										
Headaches										
Heart Disease										
Heartburn										
Hives										
Hot Flashes										
Hypertension										
Immune Disorder										

SYMPTOM	1	2	3	4	5	6	7	8	9	10
Immunization effects										
Indigestion										
Insomnia										
Irritable Bowel										
Labored breathing										
Learning Disabilities										
Liver Disorder										
Loose Stools										
Lupus										
Migraine										
Milk Allergy										
Morning Fatigue										
MS										
Nervousness										
Night Sweats										
Numbness										
Pain anywhere in body										
Palpitations of chest										
PMS										
Poor appetite										
Poor Memory										
Rashes										
Schizophrenia										
Sea Sickness										
Sexual impotency										
Skin growths										
Shortness of breath										
Sinusitis										
Swelling of joints										
Throat Constriction										
Other										
QUALITY OF LIFE	1 = Poor				10 = Excellent					
Breathing										
Thinking										
Walking										
Sleeping										
Driving										
Eating on your Own										
Cooking										
Communication										
Sports/Exercise										
Relationships										
Work/Job										
Family life										