



Lifestyle and History of Energetic Stress

Name _____ Today's Date ___ / ___ / ___ Birth Date ___ / ___ / ___

Why Are You Here? _____

Major Health Issues of Mother _____

Major Health Issues of Father _____

Some questions may be duplicated, please answer ALL question anyway to the best of your ability.

CHECK if occasional, CIRCLE if frequent or severe

Head and Neck

- Frequent headaches
- Neck pain/tightness
- Blurred vision
- Migraines
- Dental Problems
- Dizziness

Digestive

- Hemorrhoids
- Bloating stomach
- Constipation
- Diarrhea
- Acid reflux

Skin

- Bruise easily
- Open cuts/sores
- Skin allergies
- Tender areas
- Varicose Veins
- Night sweats

Cardiovascular

- Chest Pain
- High blood pressure
- Low Blood Pressure
- Swelling in feet/ankles
- Leg Cramps
- Phlebitis/thrombosis

Nervous System

- Difficulty relaxing
- Difficulty sleeping
- Nervousness
- Cold hands or feet

Female Genito/Urinary

- Lump/pain in breast
- Menstrual problems

Male Genito/Urinary

- Painful/slow urination
- Nighttime urinary freq.

Respiratory

- Sinus problems
- Asthma/bronchitis
- Allergies
- Easily out of breath

Any other problems or concerns _____

Diagnosed by Doctor: CIRCLE if current diagnosis, CHECK if treated in the past

- | | |
|---|--|
| <input type="checkbox"/> Vascular, Circulatory Disease, Arteries, Veins | <input type="checkbox"/> Arthritis/Rheumatism |
| <input type="checkbox"/> Infections or History of Infections | <input type="checkbox"/> Kidney/Bladder/Prostate |
| <input type="checkbox"/> Cancer, Tumors, or other Degenerative Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dietary Disorders, or Absorption Disorders | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Drug or Alcohol Addiction or Toxic Exposure | <input type="checkbox"/> Diabetes/Hyperglycemia |
| <input type="checkbox"/> Congenital or Inherited Birth Disorders | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Allergies or Tendency to Allergic Responses | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Any serious Trauma or Injury in History | <input type="checkbox"/> Hernia/Rupture |
| <input type="checkbox"/> Endocrine, Glandular, or Hormonal Disorders | <input type="checkbox"/> Ulcer/Colitis/Diverticulitis |
| <input type="checkbox"/> Mental or Emotional Disorders | <input type="checkbox"/> AIDS/HIV Positive |
| <input type="checkbox"/> Sensory Disorder (eyes, ears, taste, feel, or smell) | <input type="checkbox"/> Learning Disability/ADD/ADHD |
| <input type="checkbox"/> Sensitivity to Humidity, Hot, or Cold | <input type="checkbox"/> Schizophrenia/Bipolar/Psychosis |
| <input type="checkbox"/> Cognitive or Memory Disorders | |

Surgeries: Were? _____

Broken Bones/Severe Sprains: Where? _____

Organs Removed? _____

Teeth Extractions/Root Canals? _____

Ever Been Hospitalized? For: _____

Ever Been in an Accident? Describe: _____

Life Style Profile – Check All That Apply

- | | |
|---|---|
| <input type="checkbox"/> Organs removed? How Many? | <input type="checkbox"/> Personal Stress? Estimate 0 – 10 (10 being the most) |
| <input type="checkbox"/> Use prescription medications? How Many? | <input type="checkbox"/> Eat Sweets? Estimate # per day |
| <input type="checkbox"/> Use tobacco? How much? | <input type="checkbox"/> Exercise weekly? How many 15 min. sessions per week? |
| <input type="checkbox"/> Use steroids in past year? How many? | <input type="checkbox"/> Use Alcohol? Estimate # of servings per week |
| <input type="checkbox"/> Number of Amalgam fillings | <input type="checkbox"/> Use caffeine? Estimate # of servings per week |
| <input type="checkbox"/> Use recreational drugs? Times of use in past 30 days? | <input type="checkbox"/> Exposed to serious toxins or poisons? How many and what? |
| <input type="checkbox"/> Debilitating allergies? To what? | <input type="checkbox"/> Major infections in your life? How many? |
| <input type="checkbox"/> Emotional/Mental conditions? How many? | <input type="checkbox"/> Major injuries in your life? How many? |
| <input type="checkbox"/> Accept Responsibility for your health? Estimate 0 – 10 | <input type="checkbox"/> How many glasses of water do you drink a day? |
| <input type="checkbox"/> Estimate percent of fat in daily diet (20 – 30%=norm.) | <input type="checkbox"/> Do you feel overweight? How many lbs? |
| <input type="checkbox"/> Suffer from motion sickness? Often? | <input type="checkbox"/> Left (write L) or Right (write R) hand dominance? |
| <input type="checkbox"/> Personality is Introverted (I) or Extroverted (E) | <input type="checkbox"/> Sleeping difficulty, going to sleep or waking frequently |

Drugs/Prescriptions Used (now or in the past)

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Pain Medication | <input type="checkbox"/> Kidney | <input type="checkbox"/> Cancer Drugs | <input type="checkbox"/> Heart Medication |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Anti-convulsant | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Anti-depressants | <input type="checkbox"/> Steroids | <input type="checkbox"/> Digestive |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Anti-psychotic | <input type="checkbox"/> Liver | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Parkinson's | | |

Others

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Muscle Relaxant | <input type="checkbox"/> Anemia | <input type="checkbox"/> Reduce Weight |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation | <input type="checkbox"/> Mood Regulator | |

Toxic Exposures

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Beauty Salon Toxins | <input type="checkbox"/> Heavy Metals | <input type="checkbox"/> Chlorine or Fluorine | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Industrial Toxins | <input type="checkbox"/> Radiation Exposure | <input type="checkbox"/> Herbicides/Insecticides | |
| <input type="checkbox"/> Asbestos/Fiberglass | <input type="checkbox"/> Food Additives | <input type="checkbox"/> Air/Water Pollution | |

Details of Stress You Experience

Are you the primary caregiver to someone else? If yes, what's relation and age? _____

Have you recently lost a job / changed careers? _____

Have you had a recent change in major relationship/partnership? _____

Have you recently had an experience which you feel you had no control over? _____

What movements cause/aggravate pain?

Standing Stooping Kneeling Driving
 Sitting Bending Lifting Other _____

On a level of 1 – 10 (10 being the worst), what is your level of pain? (Please circle)

1 2 3 4 5 6 7 8 9 10

On the Figures Below, Shade in Any Areas Where You Experience Muscle or Joint Pain/Stiffness

