HILL COUNTRY INTENTIONAL HEALING

DATE: _____

CONFIDENTIAL WELLNESS CLIENT PROFILE

First Name: _____ Last Name: _____

Age: _____ Birthdate: _____ Sex: _____ Height: _____ Weight: _____

Best phone number: _____

Email: _____

Mailing address: # and Street _____

City: _____ State: _____ Zip: _____

Please complete this two-sided questionnaire as thoroughly as possible. This is a confidential record and will not be released, except when you have provided us with written authorization to do so. Thank you!

PRESENT HEALTH CONCERNS

Please list your most important health concerns in their order of significance.	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	

What goals do you have for the visit today?

_____

_____

_____

Please list any severe or life-threatening allergies:

_____

Explain: _____

Please list prescription & over-the-counter medications that you are currently taking, with dosages (if known):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List vitamins, minerals, herbs, homeopathic remedies, essential oils, supplements that you are currently taking with dosages:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

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PERSONAL HABITS

Please circle any of the following substances that you use regularly:
Tobacco. Coffee/Black Tea/Soda. Alcohol. How often? _____ What type? _____
Have you ever completed a detox protocol? If yes, when?_____
Do you follow any particular diet regimens or restrictions? (GF, DF, Paleo, Vegan) Other: _____
If yes, please describe briefly and specify how long you have been following this diet:

_____

Do you practice any form of mindfulness, meditation, prayer, etc.? _____
Do you exercise regularly? Yes No If yes, what type?_____
How long? _____ How often? _____

PAST HISTORY

Hospitalizations: _____
Serious illnesses and injuries: _____
Tattoos/Scars and location (C Section, Episiotomy): _____
Dental Work (Amalgam, Implants, etc.): _____
Date of last physical exam: _____ Date of last blood tests: _____
Name of primary care doctor: _____
Phone number: _____
Other practitioners that you are working with:

_____

_____

WOMEN'S HEALTH

Type of birth control: _____ How Long? _____
Are you still cycling? Yes No
If yes, is it regular? Yes No
Any symptoms? PMS. Irritability. Other:

_____

_____

_____

If no, when was your last period? _____
Uterine Oblation: Yes No Hysterectomy: Yes No If yes: Full or Partial

SOCIAL HISTORY

Please circle those that apply: Single Married Significant Other
Do you have any children? Yes No
Please list their age(s): _____

_____

_____

Hill Country Intentional Healing

Name: _____

PERSONAL & FAMILY HISTORY

CONDITION	**YES**	**RELATIONSHIP**	**DATES RESOLVED** PAST (P)/ CURRENT (C)
Alcoholism/Drug Addiction			
Allergies			
Anemia			
Arthritis			
Asthma			
Cancer			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Disease			
High Blood Pressure			
Hepatitis			
Kidney Disease			
Mental Illness			
Stroke			
Tuberculosis			
Other:			

What were your last three meals, including beverages:

_____

_____

_____

_____

_____

_____

List any other important information you would like me to know:

_____

_____

_____

_____

_____