# Health And Well Being History Form

| | |
|---|---|
| Name: | Email: |
| Address: | City, State, Zip: |
| Home Phone: | Other Phone: |
| Cellular Phone: | Referred by: |
| Date: | Date of Birth: |

**PART 1.**

* Please answer the following questions honestly and to the best of your ability.


Describe the problem(s) for which you seek help. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, etc. Please describe and include approximate dates:

List the medications (including over the counter) you are presently taking:

What daily activities are you finding difficult or are limited because of your above complaints:

Have you ever had this problem before, and if so when?

What are your goals from BodyTalk?

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

Please list any medical tests you have had within the past year:

* Please circle any of the following feelings you have experienced in the last few months.

| | | | |
|---|---|---|---|
| Abused | Paranoid | Unable to grieve | Panic |
| Criticized | Overwhelmed | Apprehensive | Intolerant |
| Overworked | Muddled | Agitated | Uncertainty |
| Paralyzed | Persecuted | Uneasy | Aggravated |
| Depressed | Guilty | Distress | Annoyed |
| Rejected | Easily irritated | Fearful | Angry |
| Despair | Anxious | Impatient | Outraged |
| Helpless | Sad | Intimidated | Nervous |
| Hopeless | Grieving | Restless | Worried |

* Please mark the circle that best describes the level of stress for the below listings.

| | | | | |
|---|---|---|---|---|
| My family stress is: | ◯ None | ◯ Minimal | ◯ Moderate | ◯ Severe |
| My relationship stress is: | ◯ None | ◯ Minimal | ◯ Moderate | ◯ Severe |
| My work stress is: | ◯ None | ◯ Minimal | ◯ Moderate | ◯ Severe |
| My financial stress is: | ◯ None | ◯ Minimal | ◯ Moderate | ◯ Severe |
| My health stress is: | ◯ None | ◯ Minimal | ◯ Moderate | ◯ Severe |
| Other stress is _____: | ◯ None | ◯ Minimal | ◯ Moderate | ◯ Severe |

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?

Do you exercise? And if so, what kind and how often? _____

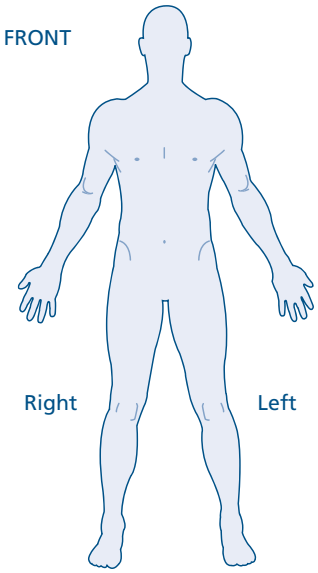
How many hours a night do you sleep? _____ Is your sleep restful? _____If not, please explain: _____

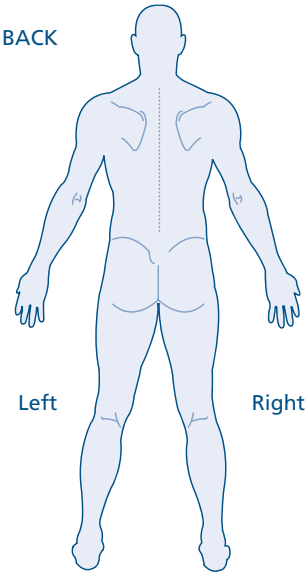
* Please list areas of pain and mark the circle that best describe the level of discomfort on a scale of 1 to 10.

1. Slight awareness of discomfort.
2-3. Awareness of discomfort as an aggravation.
4-6. Pain is strong but you are still functional.
7-9. Pain is so strong you are unable to function normally.
10. You feel like you need to go to the emergency room.

| | |
|---|---|
| 1 2 3 4 5 6 ● 8 9 10 example: neck | 1 2 3 4 5 6 7 8 9 10 |
| 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 |
| 1 2 3 4 5 6 7 8 9 10 | 1 2 3 4 5 6 7 8 9 10 |

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.




COMMENTS:

Client signature:



Practitioner's comments: