Health History Questionnaire – Adult **Date:**_____

Name:_____
First Name **Middle Initial** **Last Name**

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone (Home)_____**(Work/Cell):**_____ **E-mail**_____

Gender: **M** **F** **Birth date:**_____ **Age:**_____

Occupation:_____ **Employer**_____

Emergency Contact Name:_____ **Relationship**_____

Home Phone number:_____ **Work/Cell Phone** _____

What other healthcare are you currently receiving?

_____

_____

Primary Care Doctor:_____ **Date of last Physical Exam:**_____

Current *prescription* medications and doses:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Current supplements and non-prescription medications including any pills, liquids, ointments, suppositories – please attach a *separate page* with the name, brand and dosage of all OTC medications, herbs, vitamins, homeopathic remedies.

Allergies: List any allergies and their adverse effects (medications, food, tape, latex, chemicals, environmental allergies):

_____

_____

Present Health Concerns: Please list your most important health concerns (in order of importance).

_____

_____

_____

Health History: Age when you last felt well, if ever:_____ **Your health as a child was:** Good Fair Poor

Childhood Illnesses: (Circle any that apply) Measles Mumps Pertussis Chicken Pox Other:_____

Vaccinations: Did you receive all typical childhood vaccinations? Yes No

Please list *any adult or travel vaccinations* (date/type) and any *adverse reactions* to vaccines (date/vaccine type/reaction):

Surgeries and injuries requiring stitches: (Year/Type) Please list the most recent surgeries first.

1._____ 4._____

2._____ 5._____

3._____ 6._____

Hospitalizations: (Year/Reason)

1._____

2._____

3._____

Serious Illnesses or Injuries: (Year/Cause)

1._____ 4._____

2._____ 5._____

3._____ 6._____

Pertinent Neural Therapy History

Patient's Name Age Date

Please complete the following with the appropriate age of occurrence:

SURGERY (including all operations, even moles, etc. removed & circumcision)	AGE	SERIOUS INFECTIONS/ DISEASES (pneumonia, mono, T.B., cancer, heart attack, chronic bronchitis, colitis, mumps, measles, chicken pox, etc.)	AGE	DENTAL INTERVENTION (root canals & extractions – please try to name and number tooth – refer to dental chart on back. Also, age of first silver amalgam filling, braces, retainer, etc.)	AGE
		Typical childhood vaccinations? ___yes ___no			
TOXIC PROFESSION PAST OR PRESENT (artist, graphic designer, dentist, dental asst, gas station worker, painter, industry, computer cleaning, etc.)	AGE	PREGNANCIES/ BIRTHS/ ABORTIONS/ IUDS, EPISIOTOMY, ETC.	AGE	PRESCRIPTION OR STREET DRUGS, ALCOHOL, CIGARETTES, ETC.	AGE
				PAST:	
INJURIES/ ACCIDENTS *WITHOUT STITCHES*	AGE	INJURIES/ ACCIDENTS *WITH STITCHES*	AGE		AGE
				PRESENT:	
MAJOR PSYCHOLOGICAL TRAUMA	AGE	LONG VISITS OR LIVED IN A FOREIGN COUNTRY	AGE	KNOWN ALLERGIES	AGE
		Treated for parasites, infection? ____yes ____no			

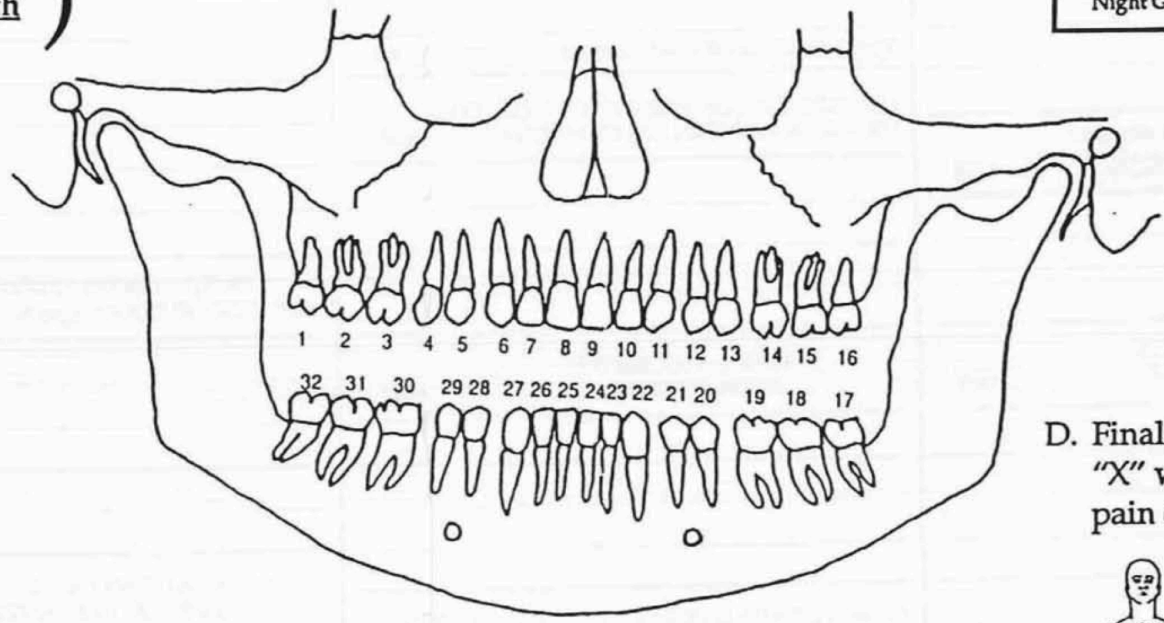
B. Please use the numbered teeth below to indicate on the other side which teeth have had dental intervention. ALSO, please use the KEY to mark appropriately on the dental chart, and answer upper/lower, if appropriate.

KEY	
Pulled teeth	X
Cavities filled	•
Crowns	■
Bridge	⌒
Root canals	o
Dentures?	___ upper ___ lower
Braces?	___ upper ___ lower
Retainer or Night Guard?	___ upper ___ lower

Dental Chart

(#1, 16, 17 & 32 are wisdom teeth)

Right side

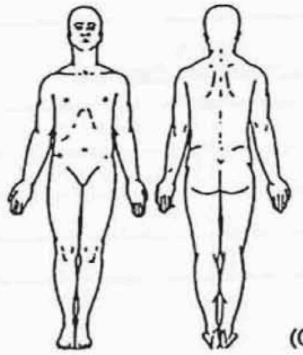


Left side

C. Write your chief complaint(s) below and indicate the approximate age of onset.

	HEALTH COMPLAINT	AGE		HEALTH COMPLAINT	AGE
1.			4.		
2.			5.		
3.			6.		

D. Finally, mark with an "X" where you have pain or dysfunction.



(Over)

RELEASE OF LIABILITY AND CONSENT FORM
FOR ART KINESEOLOGY

READ CAREFULLY – THIS AFFECTS YOUR LEGAL RIGHTS

- In exchange for participation in the activity of ART kinesiology and wellness consultation, classes, workshops or therapy organized or conducted by Tomira Baca-Craig HHP, and/or use of the property, facilities and services used by Tomira Baca-Craig HHP, I agree for myself, to the following:

- I agree to observe and obey all posted rules and warnings, and further agree to follow any oral instructions or directions given by Tomira during sessions, workshops or classes.

- I understand that my practitioner is not a doctor or licensed psychotherapist and any modalities, conversations or sessions used to support my wellness do not infer nor intend to diagnose, treat or cure physical or mental disorders.

- I recognize that there are certain risks associated with the above described activities and I assume full responsibility for personal injury to myself and further release and discharge Tomira for injury, loss or damage arising out of my use of or presence upon the facilities of Tomira, whether caused by the fault of myself, Tomira or other third parties.

- I know that I am responsible for my own health and actions and only I can heal myself. ART kinesiology, wellness consultations, and my practitioner are only tools I employ to help me. I undertake services, suggestions and directions with this in mind.

- I understand that the work that I am undertaking can be cathartic and unsettling to my everyday life. I recognize that Tomira will be touching my body at times to facilitate this work.

- I agree to cancel and/or reschedule my sessions at least 24 hours in advance of my scheduled appointments by leaving a voicemail on 949-584-1267 and if I fail to do so or do not show up for a session I will be charged the full session fee.

- I agree to indemnify and defend Tomira against all claims, causes of action, damages, judgments costs or expenses, including attorney fees and other litigation costs, which may in any way arise from my use of or presence upon the facilities Tomira uses.

- I agree to pay for all damages to the facilities of Tomira or associates caused by my negligent, reckless, or willful actions.

- Any legal or equitable claim that may arise form participation in the above shall be resolved under California law.

Tomira Baca-Craig HHP is also referred to as Tomira and Practitioner within this document, all relate to the same person and all outlined conditions and obligations apply.

I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT BY SIGNING THIS RELEASE, I VOLUNTARILY SURRENDER CERTAIN LEGAL RIGHTS.

Client

Print Name: _____ Date: _____

Signature: _____

Witness

Print Name: _____ Date: _____

Signature: _____

In case of emergency, please call _____

Phone number _____