Wellness on the Mountain

~UR Healing Connection

Name _____

Address _____

_____

Telephone

Today's Date _____

Date of Birth _____

Occupation _____

Hours worked in week: _____

Email Address _____

Is this a good method of contact? Yes No

May I add you to my email newsletter? Yes No

Emergency Contact:

Blood Type:

Main presenting symptoms (please list)	Other symptoms/concerns (list)

Past medical history (please list: hospitalization, surgery, etc)	Famiy medical history (list ailments)
	*mother:
	*father:
	*maternal mother:
	*maternal father:
	*paternal mother:
	*paternal father:

Orthodox medication & why you are taking them:	Allergies:
1	
2	
3	
4	
5	

Supplements,herbs,etc & reason taking:
1
2
3
4
5
6
7
8
9
10

Food Info

What did you typically eat as a child?

Breakfast	Lunch	Dinner		Snack	Liquids

What is your food like today?

Breakfast	Lunch	Dinner		Snack		Liquids

Do you cook?

What percentage of your food is home cooked?

Where do you get the rest from?

Do you crave sugar, coffee, or have any major addictions?

Digestion: Do you typically feel any of following after a meal: Bloating / Gas / Heartburn/ Acid Reflux/ indigestion/ etc

Explain:

Are you taking any medication for any of these issues & what kind?

Bowel Movements

Daily: 1 /2 / 3/ other How many meals a day?

Explain:

Do you like water: Y /N How much water do you drink in a day?

What else do you drink throughout day?

Allergies or Sensitivities?

Please explain:

Food:

Environmental:

Complete sentence:	The most important thing I should change in my diet, to improve my health, is…

Will family be supportive of your desire to make food and/or lifestyle changes?

Sleep	How many hours a night:	How many times do you wake typically in a night?
explain why:		
do you fall asleep right away?		

Female:	Menstruation/Pre-Meno/Post Menopause	~Menopause Symptoms (**circle those that apply**):			
~days you menstrate:					
~children: Yes / No		moodiness	insomnia	fatigue	thin hair
~how many:		depression	irritability	vag dryness	dry skin
~age mother went through menopause?		night sweats	cravings	pain at intercourse	
Date of last menstration:		hot flashes	low libido	migraines	weight gain
Additional explanation:					

Male:	Reproduction/Urination Concerns (circle those that apply)				
	urinary frequency	erectile dysfunction	lack of mental clarity/focus		memory loss
	sleep apnea	low testosterone	depression	heart palpatation	low libido
	muscle weakness	hair loss	irritability	night sweats	insomnia
	fatigue	anxiety	weight gain	mood swings	constipation
Additional explanation:					

Circulation (numbenss in hands, tingling in toes, etc) Explain, when and where:

Temperament/Mood (what is it like throughout the day?) Explain:

Respiratory Concerns: allergies/seasonal/ food/ asthma/other:

Excessive sweating: Yes / No	Body temp typically: Hot or Cold
No sweating at all: Yes / No	Explain:

Energy Level:	(explain)	Do you supplement energy with caffeine?		
upon rise		How much daily & what kind?		
mid day		coffee/tea	chocolate	energy drinks/soft drinks/ pain relief
evening		other:		

Exercise / Movement:

What activities do you do regularly? Fill in below.

Mond	Tues	Wed	Thur	Frid	Sat	Sund	other	

Do you experience any pain, stiffness or swelling? What time of day? Any triggers?

Are you working with any practitoners, healers, or other therapies currently? Please list:

Stress

What percentage of your day is consumed with stress?

How do you handle stress?

What techniques do you use to de-compress?

What causes you the most stress daily?

Is this an area of your life you need to work on?

How many hours a week do you work?

How much time do you give to 'yourself' daily? (a bath, reading a book, meditation, prayer, etc)

Goals:

Health Goal with today's visit?

Health Goals long term: (list)

Life Goals (short term)

What is your level of commitment to your health? 10-100%

PLEASE elaborate:

By signing this document, you acknowledge the understanding that all the information shared with you is for the purpose of education.
Your visit today is NOT to diagnose you.
Also, by signing you acknowledge all information provided by you is true & complete.

Your Signature Date