

Health And Well Being History Form

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Home Phone:	Other Phone:
Cellular Phone: 0408480077	Referred by:
Date:	Date of Birth: 05/03/75

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:

I have a recurring problem with thoracic pain and shoulders, ribs

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?

understand my body more

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

jini shin jitsu, meditation, massage, osteopath, chiropractor, acupuncture

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.

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

Abused	Paranoid	Unable to grieve	Panic	My family stress is:	<input type="radio"/> None	<input type="radio"/> Minimal	<input checked="" type="radio"/> Moderate	<input type="radio"/> Severe
Criticized	Overwhelmed	Apprehensive	Intolerant	My relationship stress is:	<input type="radio"/> None	<input checked="" type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Overworked	Muddled	Agitated	Uncertainty	My work stress is:	<input type="radio"/> None	<input checked="" type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Paralyzed	Persecuted	Uneasy	Aggravated	My financial stress is:	<input type="radio"/> None	<input checked="" type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Depressed	Guilty	Distress	Annoyed	My health stress is:	<input type="radio"/> None	<input checked="" type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Rejected	Easily irritated	Fearful	Angry	Other stress is	<input type="radio"/> None	<input checked="" type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Despair	Anxious	Impatient	Outraged	_____:	<input type="radio"/> None	<input checked="" type="radio"/> Minimal	<input type="radio"/> Moderate	<input type="radio"/> Severe
Helpless	Sad	Intimidated	Nervous					
Hopeless	Grieving	Restless	Worried					

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

surf, train, travel

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

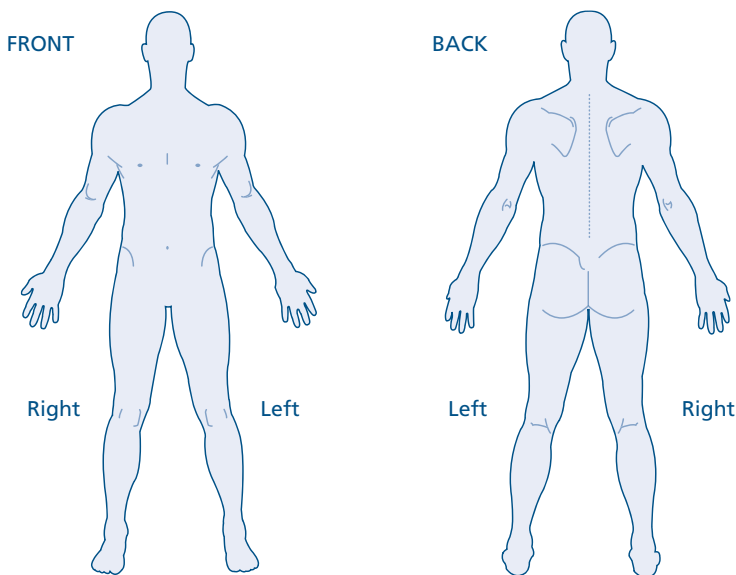
How many hours a night do you sleep? 8 Is your sleep restful? yes If not, please explain: _____

* 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.

<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input checked="" type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 example: neck	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10
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* 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:
