Holistic Healing
& Happiness

WELLNESS ASSESSMENT

The wellness assessment helps me understand how to guide you in creating a balanced lifestyle on an energetic, physical and nutritional level. An accurate history is vital to this process and helps tailor recommended sessions to your specific needs. Please let me know if your health information changes in the future so that I may adjust the sessions and modalities offered.

I. GENERAL INFORMATION

Name: _____

Street Address: _____

City, State, Zip: _____

Today's Date: _____ Date of Birth: _____

Phone #: Home: _____ Cell: _____ Work: _____

Email: _____

Occupation: _____

How did you hear about me? If referred, please list name of person.

_____

_____

Why have you come today? What are your major areas of concern?

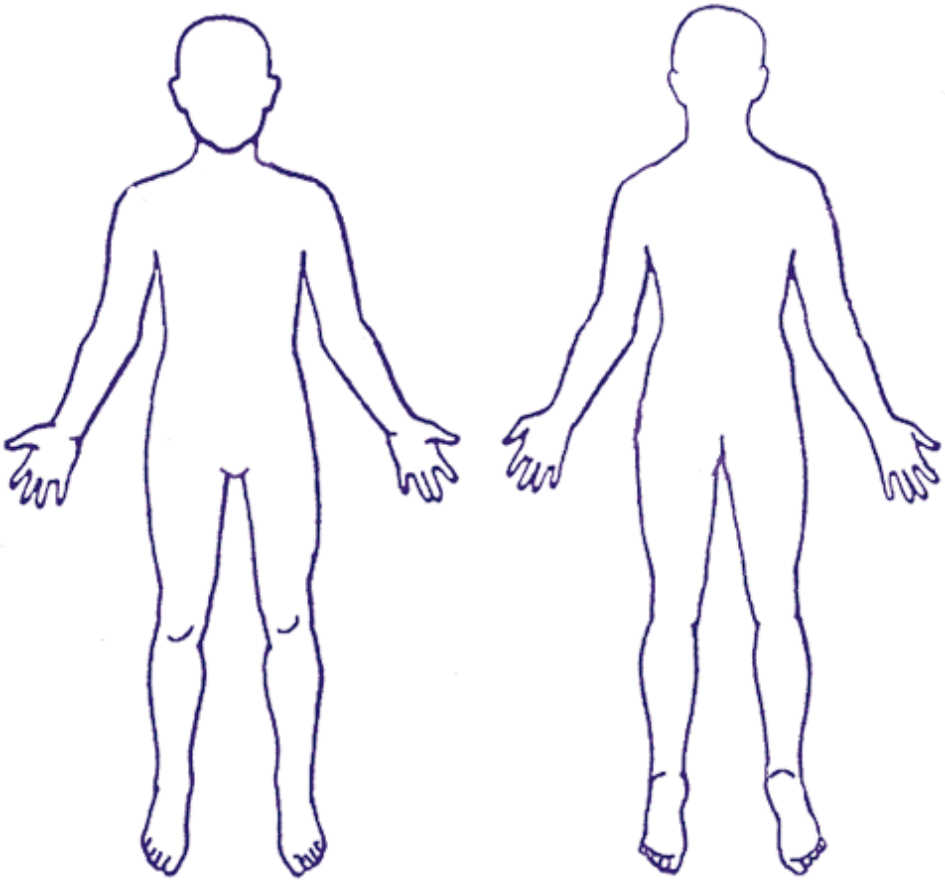
_____

_____

_____

On the body diagrams below, please circle any areas where you are experiencing pain, stiffness, and/or discomfort.

If you are experiencing it in one area and also feeling it elsewhere, please indicate this with arrows.



II. HEALTH HISTORY

Check (√) If You Have Now or Have Had in the Past

Muscle/Joint/Bone	Difficulty Swallowing	Pneumonia
Arms	Earache	Other:
Shoulders	Ear Discharge	**Digestive**
Neck (Sides)	Allergies	Poor Appetite
Neck (Back)	Hoarseness	Belching/Gas
Upper Back	Hearing Loss	Constipation
Mid Back	Nosebleeds	Diarrhea
Lower Back	Persistent Cough	Nausea
Degenerative Discs	Ringing in Ears	Vomiting
Feet	Sinus Infections	Ulcers
Hands/Wrists	Swollen Glands	Other
Hips	Glasses or Contacts	**Genito-Urinary**
Jaw	Other:	Blood in Urine
Knees	**Skin**	Frequent Urination
Legs	Bruise Easily	Poor Bladder Control
Osteoarthritis	Rashes	Painful Urination
Osteoporosis	Itching	Other:
Other:	Dryness	**General Symptoms**
Cardiovascular	Other:	Fainting
High Cholesterol	**Infections**	Dizziness
High Blood Pressure	Hepatitis	Loss of Sleep
Low Blood Pressure	Tuberculosis	Fatigue
Coronary Artery Disease	HIV	Nervousness
Chest Pain	Herpes	Sudden Weight Loss/Gain
Palpitations	MRSA	Numbness
Irregular Heartbeat	Frequent Colds	Paralysis
Rapid Heartbeat	Athlete's Foot/Fungus	Headaches/Migraines
Varicose Veins	Other:	Other:
Swelling in Ankles	**Respiratory**	**Women Only**
Poor Circulation	Chronic Cough	If Pregnant, Due Date:
Other:	Bronchitis	Painful Menstruation
Eye, Ear, Nose, Throat	Asthma	Heavy Flow
Bleeding in Gums	Hay Fever	Irregular Cycle
Blurred Vision	Difficulty Breathing	Pre-Menopausal
Crossed Eyes	Smoking	Post-Menopausal/Hot Flashes
Double Vision	Emphysema	Other:

OTHER CONDITIONS

Check (√) If You Have Now or Have Had in the Past

Anemia	Goiter	Pneumonia
Anorexia	Gout	Polio
Appendicitis	Heart Disease	Prostate Problems
Bleeding Disorders	Heart Murmur	Psychiatric Care
Breast Lump	Hernia	Rheumatic Fever
Bulimia	Irritable Bowel/Colitis	Scarlet Fever
Cancer (Specify)	Kidney Disease	Stroke
Cataracts	Liver Disease	Thyroid Problems
Chicken Pox/Shingles	Measles	Tonsillitis
Chron's Disease	Miscarriage	Tuberculosis
Depression	Mononucleosis	Typhoid Fever
Diabetes (Type 1 or 2)	Multiple Sclerosis	Vaginal Infections
Epilepsy	Mumps	Venereal Disease
Glaucoma	Osteoporosis	Other:

MEDICATIONS: List Those You Are Currently Taking (Prescription and Over-the-Counter):

_____

_____

ALLERGIES:

1. Are you sensitive to fragrances or perfumes? Yes _____ No _____

2. Are you allergic to any foods, medicines or other materials? If YES, please list:

_____

_____

PAST SURGERIES OR ILLNESSES:

1. Have you had surgery in the past?
   If Yes, for What?

_____

_____

2. Have you had any serious illnesses or injuries in the past?
   If Yes, Explain:

_____

_____

_____

III. LIFESTYLE

1. Do you have any difficulty sleeping? Yes _____ No _____

   If Yes, Describe: _____

2. On a scale of 1- 10, how fatigued do you feel most of the time? (1 = lowest, 10 = highest)

_____

3. On a Scale of 1 – 10, how stressed do you feel most of the time? (1 = lowest; 10 = highest)

_____

4. Is there anything in your life (past or present) that causes you physical and/or emotional stress or trauma?

   Yes _____ No _____

   If Yes, Explain: _____

_____

_____

5. What symptoms of stress do you experience? (Examples: headache, high blood pressure, digestive issues, insomnia, fatigue, lethargy, anxiety, depression, anger, fear, irritability, etc.)

_____

6. What do you do to help relieve your stress? (Examples: exercise, listen to music, meditate, eat, sleep, etc.)

_____

7. Is there a particular season that you prefer? Yes _____ No _____

List: _____

8. Is there a particular season that you dislike? Yes _____ No _____

List: _____

9. Is there a particular taste you prefer? Yes _____ No _____

List: _____

10. How often do you exercise & type of exercise?

_____

_____

IV. NUTRITIONAL OVERVIEW

1. Please indicate: Height: _____ Weight: _____

2. Are you satisfied with your current weight & nutrition? Yes _____ No _____

If No, Explain: _____

3. Do you think that you mostly eat healthy foods? Yes _____ No _____

If No, Explain: _____

4. Do you take vitamins or supplements? Yes _____ No _____

List: _____

5. Are you on any special dietary plan or do use any particular dietary products?

List: _____

6. Do you have any strong food preferences? Yes _____ No _____

Likes: _____

Dislikes: _____

Please Read Carefully and Sign

The information I have provided is true and complete to the best of my knowledge. I understand the information on this form is confidential and will not be released without my written consent. I understand that Holistic Healing & Happiness and practitioners do not provide medical advice, diagnose and treat any medical conditions, or prescribe medications. No guarantees or warrantees are made about the effectiveness of any modality. I understand that complementary modalities are not a substitute for medical treatment, and I should seek a licensed physician for any medical condition.

I consent to sessions/modalities recommended to me by Holistic Healing & Happiness.

PRINT NAME: _____ Date: _____

LEGAL GUARDIAN NAME (Print): _____

SIGNATURE: _____

Holistic Healing
& Happiness

WELLNESS PLAN

(To Be Completed by Practitioner)

I. OPPORTUNITIES FOR HEALTHY LIVING

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

II. RECOMMENDATIONS (Type of Modality, Frequency, Length of Time, etc.)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Practitioner Name: _____

Practitioner Signature: _____

Date: _____

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