Name: D.O.B:

Email Address: Appointment Date:

Phone Number:

## *About Your Health:*

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, which have resulted in poor health. During your sessions we will begin to correct these layers of damage and recover your innate health potential.

## *Loss of Wellness (Birth - Age 5)*

Let's begin at birth when you may have first damaged your nerve system, lost your wellness, and began your journey to ill health.

Please check Yes / No and add comments where applicable:

### *Birth Process*

Was the delivery long and/or difficult? Yes / No

Comment:

Were Forceps or suction used? Yes / No

Comment:

Was the birth Cesarean? Yes / No

Comment:

Breech / Cephalic? Yes / No

Comment:

Do you know of any stressful situation that may have been present for your mother or father or both?

## *Growth and Development*

Did you roll out of bed or have any falls as a child? Yes / No

Any Childhood illnesses? Yes / No

Did you have other traumas? Yes / No

What?

When?

Did you have colic, reflux or difficulty feeding? Yes / No

Were there any stressful events that occurred in this time? Yes / No

## *Loss of Whole Body Health (Age 5 - Present)*

As you increase the layer of damage you probably begin to experience symptoms and random bouts of sickness.

Did you / Do you smoke? Never Reformed smoker Daily

Do you / Do you drink Alcohol? Never Did previously Weekly Daily

Did you / Do you take recreational Drugs? Never Did previously Weekly Daily

Have you recently taken recreational drugs? Yes No

Please list them

Number of days/weeks since taking.

Do you take over the counter Drugs? (Prescriptive or Non-prescriptive)

Never Have recently Currently taking

Have you recently taken prescription drugs? If so, please list them:

Number of days/weeks since taking.

*Please include the drug function for eg, blood pressure, anti-arthritis etc*

Diet (do you eat healthy?) Yes always I try to eat Healthy No

Have you been in any Accidents? Yes / No

Have you had surgery and organs removed or replaced? Yes / No

Sleeping habits? Yes / No *Trouble sleeping, sleep debt, wake up tired, etc.*

Sleeping Posture: Side Stomach Back

Did you / Do you have occupational stress? Yes / No

Physical and/or Mental stress? Yes / No

Hobby / Sports injuries? Yes / No

Other Traumas or problems? Yes / No

Were there any stressful events that have caused an impact on your health and wellbeing?

## *Present State of Health (Symptoms)*

What is your body telling you right now? What symptoms are you experiencing? Please explain and describe what is happening in your body

When did this start?

What do you think the cause is?

What activities aggravate your condition?

What lessens your condition?

Is this condition interfering with: Work Sleep Routine Other:

What is this stopping you from doing?

If this was to go away tomorrow, what would be different about your life?

Are you living the life you would like to be?

On a scale of 0-10, how happy are you?

1 2 3 4 5 6 7 8 9 10

On a scale of 0-10, how much stress is in your life?

1 2 3 4 5 6 7 8 9 10

Are you ready to make changes to your life in order to heal, even if these changes could be inconvenient to your lifestyle?

## *Any Other Symptoms you are experiencing (Please check if applicable)*

B

Addictions
Allergies
Arthritis
Cancer
Candida
Infertility
Lower back/tailbone pain
Hemorrhoids
Overweight
Gout
Osteoporosis
Teeth problems
Feet issues
Hand issues
Poor physical health
Depression
Nervous system issues
Neurological disorders
Numb toes
Numbness in fingers
Stress
Tension & Irritability
Nervousness
Feeling fearful
Feeling unsupported
Feeling ungrounded

F

Anxiety
Apathy
AIDS
Curvature of the lower spine
PMS
IBS
Impotency
Abdominal cramps
Menstrual pain
Lower back pain
Hip/groin issues
Leukemia
Ovarian cysts
Fibroid tumors
Endometriosis
Fungus
Muscular dystrophy
Eczema
Psoriasis
Ringworm
Vomiting
Ankle problems
Wrist problems
Sciatica
Feeling dissatisfied
Feeling sorrow
Feeling stuck
Emotionally disconnected

Po

Anorexia
Baldness
Liver conditions
Diabetes
Shingles
Indigestion
Heartburn
Chronic fatigue
Middle back pain
Colitis
Conjunctivitis
Cystic fibrosis
Gall stones
Gastritis
Gout
Hepatitis
Infection
Kidney stones/issues
Parasites
Ulcers
Disc problems
Knee pain/problems
Elbow problems
Food allergies
Fibromyalgia
Constipation
Diarrhea
Indifferent
Feeling weak
Anger
Lethargy

C

Arthritis
Bronchitis
Poor circulation
Shortness of breath
Asthma
Upper back pain
Shoulder/arm pain
Breast problems
Chest pain
Difficulty breathing
Cystic fibrosis (chest area)
Heart attack
Hypertension/High blood pressure
Rheumatism
Tuberculosis
Warts
Hate
Unforgiving

Pa

Shortness of breath
Tonsillitis
Thyroid condition
Neck pain/Stiff neck
Teeth grinding
Goiter
Laryngitis
Swollen glands
Sore throats

A

Migraine
Dizziness
Brain tumor
Low energy
Chronic fatigue
Memory issue/brain fog
TMJ

Pau

Headaches
Insomnia
Sinusitis
Tinnitus/Ears ring
Cold/Flu
Nightmares
Epilepsy
Stroke
MS
Parkinson's disease
Paralysis
Snoring
Fainting
Fever
Light bother eyes
Hearing problem
Balance loss
Lost of smell

What are you looking to get out of this session (set of sessions)?

What is your relationship like to your mother?

What is your relationship like to your father?

Have you had any trauma or abuse in your life?

Please let us know in a few paragraphs, how we can assist you and help you the most.

By signing this form, I agree and consent to the healing work while I am on this course of treatment.

I understand that with any healing process and work on my body, my symptoms may worsen before they get better.
I understand this program is designed to assist the body with healing by helping to remove stressors from the body.
I understand that healing takes time and there is no quick immediate fix to my problem, and health is a process.

I have freely decided to undergo the recommended treatment and hereby give my full consent to the treatment.
I agree and accept the No-Show & Cancellation Policy by checking this box:

**No Show & Cancellation Policy**
**Cancellation Fee**
**$50 fee for less than 48-hour notice to change or cancel.**

**No-Show Fee**
**$50 for no-shows.**

**Late Policy**
**Out of respect for our clientele and staff schedules, treatments for clients arriving more than 15 minutes late will be honored at our discretion.**

Name:

Signature:

Date: