



Life Strength & Health Holistic
HEALTH HISTORY INTAKE FORM

Name: _____ Date: _____

Address: _____

Town/City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Mobil/Pager: _____ Email: _____

Occupation: _____ Employer: _____

DOB: _____ Sex: _____ Marital Status: _____ Spouse's Name: _____

In case of emergency contact: _____ Relationship: _____

Please Check the services that you will be receiving today?

Detoxification Program 3 Month Program One Time Consultation

Colon Hyrdotherapy Massage Therapy Personal Training

Colon Health Program

How did you hear about us?

Brochure Business Card Internet Email

Other Advertisement

Refer By Whom: _____

May I contact you with Brochures, Specials and Notices? Yes No

Are you presently under a physician's care? Y / N
For what condition? _____

List medications you are taking: _____

Are you allergic to any medications? _____

Serious illness / hospitalizations / injury? _____

What is your chief health concern? _____

Other concerns? _____

Are there any other healers, helpers, pets, or therapies with which you are involved? Y / N
If so please list: _____

How many glasses of water do you drink daily? ____ Do you eat a lot of dairy? Y / N

Do you often get tired after eating? Y / N

Do you shake, get light headed or anxious when you miss a meal? Y / N

Do you wake-up in the middle of the night in a cold sweat or feeling hungry? Y / N

Current Weight: _____ Weight six months ago: ____ One Yr Ago: _____

Would you like your weight to be different? Y / N If so what? _____

Do you sleep well? Y / N Do you wake up at nights? Y / N What time(s)? _____

What time do you generally get up in the morning? _____

What's your food like these days?

Breakfast _____

Lunch _____ Dinner _____

Snacks _____ Liquids _____

Circle the foods you eat on a daily basis:

Starchy	Vegetable	Rice	Meat	Fish	Eggs
Green	Vegetables	White Flour	Fruits	Nuts	Butter
Beans / Legumes	Whole Grains	Seeds	Fowl	Vegetable Oils	

Are you allergic to any foods? _____

What % of your foods is home cooked? _____ %
Where do you get the rest from? _____

How many meals do you eat a day? _____

Do your hands often tingle? Y / N Do your feet often burn? Y / N

Do you often get leg cramps Are your hands and feet usually cold? Y / N

Do you often feel cold when others are warm? Y / N

What conditions or diseases run in your family _____

Women

Are your periods regular? Y / N How many days is your flow? ____
How Frequent? _____

Painful or symptomatic? _____ Please explain: _____

Do you presently use birth control? Y / N

Have you used birth control in the past? Y / N How long? __

Have you had a tubal ligation? Y / N

Grade your symptoms for your last menstrual cycle. If it is unusual, grade according to a typical cycle.

Use the following Key.

- 0 = None
- 1 = Mild
- 2 = Moderate (symptoms present and interfere, but you can function)
- 3 = Severe (cannot function without medication, disabling)

<u>Symptoms</u>	<u>Week Before</u>	<u>Week After Menses Ends</u>
<u>PMT - A</u>		
Nervous tension	_____	_____
Mood swings	_____	_____
Irritability	_____	_____
Anxiety	_____	_____
 <u>PMT - H</u>		
Swelling of extremities		
Weight gain (1 to 4 lbs)	_____	_____
Breast tenderness	_____	_____
Abdominal bloating	_____	_____
 <u>PMT - C</u>		
Headaches		
Crave Sweets	_____	_____
Increased appetite	_____	_____
Heart pounds	_____	_____
Fatigue	_____	_____
Dizziness or fainting	_____	_____
 <u>PMT - D</u>		
Depression		
Forgetfulness	_____	_____
Crying	_____	_____
Confusion	_____	_____
Insomnia	_____	_____

Do you drink coffee, smoke cigarettes, or have any major addiction? _____

What role does exercise play in your life? _____

Describe your daily / weekly exercise: _____

Are you under a lot of stress? Y / N Do you use any stress reduction techniques? Y / N

Is so what? _____

Is your sex drive: _____ Poor _____ Fair _____ Good _____ Very Good?

Is your appetite: _____ Poor _____ Fair _____ Good _____ Very Good?

Is your mood usually: _____ Poor _____ Fair _____ Good _____ Very Good?

Have you been diagnosed as: _____ Atherosclerosis What is your Blood Pressure?

_____ Arteriosclerosis

_____ Angina

What are your blood levels of Cholesterol HDL _____ LDL _____ Triglycerides _____

How often do you have a bowel movement (BM)? _____

What is the usual color of your stool? _____

What is the consistency of your stool? () Hard & Dry () Loose, Like Pudding

() Firm & Moist () Watery, Diarrhea

Do you use laxatives? Y / N If so what brands? _____

Do you have? Hemorrhoids: Y/N Rectal Bleeding: Y/N Strain when you have a BM: Y/N

Have you had? Recent Barium Enema: _____ Colonoscopy: _____ Colon Surgery: _____

Rectal Surgery: _____

If you have ever had any of these procedures please list the type and when it was performed _____

Please check if you currently have or have ever had any of the following, or been diagnosed as having problems with any of the following:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Sigmoidoscopy | <input type="checkbox"/> Colds / Flu |
| <input type="checkbox"/> Coated Tongue | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Nerves |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Chron's Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Frequent use of laxatives | <input type="checkbox"/> Severe Hemorrhoids | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Indigestion after meals | <input type="checkbox"/> Severe cardiac disease | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Gas after eating | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Painful / Difficult BMs | <input type="checkbox"/> Carcinoma of the colon | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Burning stomach sensations | <input type="checkbox"/> Fissures / Fistulas | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Acid food upset | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Greasy food upset | <input type="checkbox"/> Advanced Pregnancy | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Frequent sour stomach | <input type="checkbox"/> Severe Anemia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hunger between meals | <input type="checkbox"/> Abdominal Hernia | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Early pregnancy | <input type="checkbox"/> GI Hemorrhage | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Recent Colon Surgery | <input type="checkbox"/> Edema |
| <input type="checkbox"/> (Ulcerative) Colitis | <input type="checkbox"/> Abdominal Distension | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Flatulence | <input type="checkbox"/> Circulation |
| <input type="checkbox"/> Atonic Colon | <input type="checkbox"/> Barium enemas | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Parasites | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Bladder |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Acne / Boils | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Eczema | <input type="checkbox"/> Sinuses |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Cysts / Tumors | <input type="checkbox"/> Ovaries |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Spine Back | <input type="checkbox"/> Breasts |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Vaginitis |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Kidneys |
| <input type="checkbox"/> Spleen | <input type="checkbox"/> Urinary Infections | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Varicose Veins | |

Answer Only If You Are Receiving A Colonic

Why have you chosen to have a Colon Hydrotherapy Session(s)?

() 9th Amendment Right to Self-Prescribe

() Doctor's Referral

() Other: _____

If there is any other information you would like to share with the Colon Hydrotherapist, please use this space to do so:

Answer Only If you Are Receiving A Massage

Is this your first professional massage If not, how frequent do you get a massage and what types? _____

What do you want to accomplish from todays massage? _____

Do you have any injuries or conditions that would interfere? Y/N

Do you have any skin rashes? Y/N If so where? _____

Do you have uncontrolled high blood pressure? Y/N

Do you have any broken bones or sprains? If so where? _____

Do you have any varicose veins? Y/N If so where? _____

Are you aware of any health issues that would prohibit you from receiving a massage? Y/N

If so what? _____

Please follow the instructions of the Therapist. You must be draped/covered at all times. Absolutely NO sexual activity is permitted during the session!

PLEASE READ FULLY AND SIGN BELOW

The above information is accurate and true to the best of my knowledge. I understand that the health practitioners at Life Strength & Health Holistic Center do not diagnose disease, prescribe medication or manipulate bones. I further understand that the holistic services offered at Life Strength & Health Holistic Center is not a substitute for medical attention or examination. I take full responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged 50% of the price of the missed session.

Signature: _____ Date: _____