Living Anointed
810.423.5721

Health and Wellness Form
~ Confidential History ~

PLEASE PRINT! **DATE:**

Name: **Phone#:**

Address: **City:** **State:** **Zip:**

Occupation: **How Long:**

Height: **Weight:** **Birth Date:** **Age:** ❑**F** ❑**M**

What do you want us to help you with, please list in order of importance:

PERSONAL CURRENT MEDICATIONS (over the counter & RX)

Antacids, Antifungals, Anxiety Medication, High Blood Pressure, Hydrocortisone Cream, Antibiotics, Antihistamines, Aspirin/Tylenol, High Cholesterol, Oral Contraceptives, Antidepressants, Anti-Inflammatories, Diuretics, Blood Thinners, Hormone Replacement, Thyroid Hormones etc., **If you have a list already you may attach it.

PERSONAL HEALTH HISTORY

Please list all Surgeries and Ailments **Pain? 1 lowest – 10 highest**

Allergies:

Gallbladder: YES or NO If No – Date Removed:

Water Intake: ounces per day *You need half your body weight in ounces in water a day!*

DIET: What does your daily diet consist of?

List the 3 worst foods you eat during an avg. week:

List the 3 healthiest foods you eat during an avg. week:

Eating Out #/Week: Eat Meat after 3pm: Y N Do you eat late at night? Y N

Vegetable Intake #/Day raw / steamed / frozen / canned

Fruit Intake #/Day raw / steamed / frozen / canned Nuts/Seeds #/day:

Cravings for: Sugar / bread / pasta?

Coffee #/Day: Soda #/Day: Diet Soda #/Day: Alcohol#/Day:

Do you depend on coffee or soda to keep yourself going or get started?

Get lightheaded when a meal is missed? Y N Shaky, jittery, tremors?

Comments:

Bowel Movements: # per day or week: BM's are (circle): Painful/ Difficult/ Easy/ Smell Bad/ Bloated/ Diarrhea/ Constipation/ Dry/ Soft / little rocks Flatulence: Rare/ Occasional/ Frequent

Have you ever had a colonic? Y N When:

Urination: # during the Day: # at Night: Difficulty/Dribbling/ Pain:

Sleep: Bedtime: Hrs/Nightly: Do you awake feeling rested? Y N

Do you require excessive amounts of sleep to function properly? Y N

Stress level at HOME – scale of 1-10 during the avg. week:

Stress level at WORK – scale of 1-10 during the avg. week:

Easily agitated, upset, nervous? Y N Poor Memory/Forgetful/ Fogginess: Y N

Depression/Lack of Motivation: Y N Mood Swings? Y N When?

Pain inside of legs or heels: Y N Leg Nervousness at night: Y N

Lack of Menstruation Alternating cycle lengths Blood flow:

Hot Flashes: Y N Frequency: Menopausal: Y N

Painful intercourse, vaginal pain: Y N

Yeast or Vaginoses Infections: Y N How often:

Morning erections: Y N Prostrate: Y N Diminished Libido: Y N

Malaria: Y N If yes, when: Hepatitis: Y N If yes, when:

Exercise: Y N Type and how often:

My job is not to convince or beg you to improve your health and wellbeing. This is something *you* have to want to do. All things are possible if your proactive in the quest ☺

It is not the intention to provide specific medical advice, but rather to share research and experiences. My hopes are that you may better understand your own health and any challenges, from a more natural perspective. I encourage you to make your own health care decisions based upon your research and in partnership with a qualified health care professional. I understand that I am responsible for my own health.

Client Signature: X **Date:**

(For Clients 18 or under, the signature & attendance of the parent or guardian for insertions is required) **Revised 3/2010**