A TOUCH OF WELLNESS

MASSAGE & HEALTH CENTER & CLINIC

You're in great hands!

CLIENT INFORMATION

Name _____ Ht._____ Wt._____ Age _____

Address _____ City _____State _____ Zip _____

D.O.B. _____

Home Phone _____ Work Phone _____ Fax _____

Employment _____Family Physician _____ Cardiologist. _____

HEALTH QUESTIONAIRE AND SELF-ASSESSMENT

What is Your Body Telling You?

		Thyroid/Parathyroid (Glandular System)
Yes	No	Are you overweight?
Yes	No	Do you get cold hands and feet?
Yes	No	Do you have hair loss or are you bald or going bald?
Yes	No	Is it easy to put on weight and hard to loose it?
Yes	No	Are your fingernails ridged, brittle or weak?
Yes	No	Do you have varicose or spider veins?
Yes	No	Do you, or have you had hemorrhoids?
Yes	No	Do you get cramping in your muscles?
Strong	**Weak**	Is your bladder strong or weak?
Yes	No	Do you have an irregular heartbeat?
Yes	No	Do you have Mitral Valve Prolapse *(Heart Murmur)?*
Yes	No	Do you get headaches or migraines?
Yes	No	Have you now or have you ever had a hernia?
Yes	No	Have you ever had an aneurysm?
Yes	No	Do you have osteoporosis? .
Yes	No	Do you have scoliosis?
Yes	No	Do you get irritable easily?
Yes	No	Do you have low energy levels?
Yes	No	Do you suffer from symptoms of depression?
Yes	No	Did you score low on your bone density tests?
Yes	No	Do your tests come back showing Low Calcium levels?
Yes	No	Do you have, or have you ever had, a goiter?
Yes	No	Do you have spine deterioration or herniated discs?
Yes	No	Have you been diagnosed with Hashimoto or Reidel disease?
Yes	No	*(Or any family member?)*_____
Yes	No	Do you sweat profusely or hardly at all?

		Adrenal Glands (Glandular System)
		Medulla (Adrenal)
Yes	No	Do you have M.S., Parkinson's or Palsy?
Yes	No	Do you have anxiety attacks or feel overly anxious?
Yes	No	Do you feel excessive shyness, or inferior to others?
Yes	No	Do you have low blood pressure *(below* 118 *systolic)?*
Yes	No	Do you have tremors, nervous legs, etc.?
Yes	No	Do you have tinnitis *(ringing in the ears)?*
Yes	No	Do you have S.O.B. *(shortness of breath)* or is it hard to take a deep breath?
Yes	No	Do you have heart arrhythmias?
Yes	No	Do you have a hard time sleeping?
Yes	No	Do you have Chronic Fatigue Syndrome?
Yes	No	Do you get tired easily?
Yes	No	Have you ever been diagnosed with Addison's Disease or with Congenital Adrenal Hyperplasia?
		Cortex *(Adrenal)*
Yes	No	Do you have elevated blood cholesterol levels?
Yes	No	Do you have lower back weakness?
Yes	No	Do you have, or have you had, sciatica?
Yes	No	Do you have arthritis or bursitis?
Yes	No	Do you have any "itis's *(inflammatory conditions)?* *Explain:*

		Female Only
Yes	No	Are your menstruations irregular?
Yes	No	Do you get excessive bleeding during menstruation?
Yes	No	Do you have or have you had ovarian cysts?
Yes	No	Do you have or did you have fibroids?
Yes	No	Do you have or did you have endometriosis or A-typical cells?
Yes	No	Are you fibrocystic?
Yes	No	Do you have fibromyalgia or scleroderma?
Yes	No	Do you get sore breasts, especially during menstruation?
Yes	No	Do you have a low or excessive sex drive?
Yes	No	Have you had a hysterectomy? When?_____ *Partial*_____ *Complete* _____ Anything further to add: _____
Yes	No	Did they take any other organs out at the same time? (*c. a. Gallbladder)*
Yes	No	Have you had a D & C?
Yes	No	Have you had a miscarriage?
Yes	No	Have you had difficulty in conceiving children?
		Other

		Male Only
Yes	No	Do you have prostatitis *(frequent urination esp. at night)?* *If yes, how often?*_____
Yes	No	Do you have prostate cancer? PSA count's:_____
Yes	No	Do you have testicular hypertrophy *(enlargement)?*
Yes	No	Do you have a low or excessive sex drive?
Yes	No	Do you have erection problems?
Yes	No	Do you have premature ejaculation?
		Other

		Pancreas
Yes	No	Do you get gas after you eat?
Yes	No	Do you feel your foods just sitting in your stomach?
Yes	No	Do you have Acid Reflux?
Yes	No	Do you see any undigested foods in your stools?
Yes	No	Do you have hypoglycemia *(Low Blood Sugar)?*
Yes	No	Do you have Diabetes *(High Blood Sugar)?* Type I ____ or Type II _____
Yes	No	Are you thin and have a hard time putting on weight?
Yes	No	Do you have gastritis or enteritis?
Yes	No	Do your foods pass right through you *(diarrhea)?*
Yes	No	Do you have moles on your body?

		Gastro-Intestinal Tract
Yes	No	Is your tongue coated *(white, yellow, green or brown)*, especially in the morning?
Yes	No	Do you have a Hiatus Hernia?
Yes	No	Do you have Gastritis?
Yes	No	Do you have Enteritis?
Yes	No	Do you have Colitis?
Yes	No	Do you have Diverticulitis?
Yes	No	Do you get or have Diarrhea?
Yes	No	Do you get or have Constipation?
Daily X ____	Week X ____	How often do you have a Bowel Movement?
Yes	No	Have you ever had stomach or intestinal ulcers? When? _____
Yes	No	Do you or have you ever had any type of gastro-intestinal cancers: stomach, colon, rectal, etc. Explain:
Yes	No	Do you have Crohn's Disease?
Yes	No	Do you have "gas" problems?
Yes	No	Other GI problems:

		Liver/Gallbladder/Blood
Yes	No	Do you have a problem digesting fats?
Yes	No	Do fats or dairy foods cause bloating and/or pain in the stomach area?

		Liver/Gallbladder/Blood (continued…)
Yes	No	Are your stools white or very light brown in color?
Yes	No	Do you get pain in the middle of your back *(especially after eating)?*
Yes	No	Do you get pain behind the right, lower rib area?
Yes	No	Do you have "liver" or brown spots on your skin? *(not freckles)*
Yes	No	Do you have any skin pigmentation changes?
Yes	No	Do you have skin problems? If so, what type? _____
Yes	No	Are you anemic?
Yes	No	Do you have, or have you ever had, hepatitis? A____, B____, C_____

		Heart & Circulation
Yes	No	Do you have any gray hair?
Yes	No	Do you have a hard time remembering things?
Yes	No	Do your legs get tired or cramp after you walk?
Yes	No	Do you bruise easily?
Yes	No	Do you get chest pains or angina?
Yes	No	Have you ever had a heart attack *(Myocardial Infarction)?*
Yes	No	Have you ever had open-heart surgery?
Yes	No	Do you have heart arrhythmia's? What kind? _____
Yes	No	Do you have a heart murmur or Mitral Valve Prolapse?
Yes	No	Do you ever feel pressure on your chest?
Yes	No	Do you get "prickly" pains anywhere, especially in the heart area? Where? _____
Yes	No	Do you have, or have you ever had High Blood Pressure?
		Your average Blood Pressure is _____over _____

		Skin
Yes	No	Do you get or have skin rashes?
Yes	No	Do you get skin blemishes?
Yes	No	Do you have Eczema or Dermatitis?
Yes	No	Do you have Psoriasis?
Yes	No	Do you itch anywhere? Where? _____
Yes	No	Is your skin dry?
Yes	No	Is your skin excessively oily?
Yes	No	Do you get or have dandruff?

		Lymphatic System
Yes	No	Are you allergic to anything? What? _____
Yes	No	Do you ever get colds or flu-like symptoms?
Yes	No	Do you have sinus problems?
Yes	No	Do you have or get sore throats?
Yes	No	Do you have swollen lymph nodes?
Yes	No	Do you have or had tumors? What type? *Fatty ___ Benign____ Cancerous ___* *Where?*_____

		Lymphatic System (continued…)
Yes	No	Do you have a low platelet count (blood)?
Yes	No	Is your immune system low or sluggish?
Yes	No	Have you had appendicitis or an appendectomy? When? _____
Yes	No	Do you get boils, pimples, and the like?
Yes	No	Do you have allergies?
Yes	No	Have you ever had abscesses?
Yes	No	Have you ever had toxemia?
Yes	No	Do you have, or have you had, cellulitis?
Yes	No	Have you ever had gout?
Yes	No	Do you get blurred vision?
Yes	No	Do you have mucus in your eyes when you wake up in the morning?
Yes	No	Do you snore?
Yes	No	Do you have sleep apnea?
Yes	No	Have you had your tonsils out? What age? _____

		Kidneys & Bladder
Yes	No	Have you ever had a urinary tract infection *(UTI's)?*
Yes	No	Have you ever had "burning" upon urination?
Yes	No	Do you have problems holding your bladder *(para-thyroid)?*
Yes	No	Have you ever had kidney stones?
Yes	No	Do you have bags under your eyes *(esp. in the morning)?*
Yes	No	Is your urine flow restricted?
Yes	No	Do you get cramping or pain on either side of your mid-to-lower back?
Yes	No	Do you or did you ever have nephritis?
Yes	No	Do you or did you ever have cystitis?

		Lungs
Yes	No	Do you get or have (or have had) bronchitis?
Yes	No	Do you get or have (or have had) emphysema?
Yes	No	Do you get or have (or have had) asthma?
Yes	No	Do you get or have (or have had) C.O.P.D.?
Yes	No	Are you on inhalers or nebulizers? How often? _____ What type? _____
Yes	No	Do you know what your oxygen saturation is?
Yes	No	Do you get pain when you breathe?
Yes	No	Do you get pain when you take a deep breath?
Yes	No	Did you ever or do you have lung cancer?
Yes	No	Do you have a collapsed lung?
Yes	No	Are you a smoker? How often? # per day _____
Yes	No	Have you ever had pneumonia?
Yes	No	Have you ever worked around toxic chemicals, in coalmines or around asbestos?
Yes	No	Do you cough a lot?
Yes	No	Do you get any mucus when you cough? *What color is the mucus?* _____

Other (What are your main health complaints or concerns?)

Please list and elaborate on any conditions or symptoms that this questionnaire has not covered or asked you.

Past Surgeries

Please list any past surgeries you have had *(e.g. tonsils removed, hysterectomies, open heart surgery. etc.)*

Surgery	***Year***

Chemical Medications

Please list any chemical medications that you are presently taking:

Medication	***Reason:***

Natural Supplements

Please list any natural supplements you are currently taking:

Supplements: Vitamins, Minerals,	***Herbs and/or Botanicals***

Allergies

Please list anything that you are allergic to:

Allergy	*Approx date/year you first noticed the allergy*

Genetic History

Mom:
Dad:
Maternal Grandfather:
(Maternal) Grandmother:
(Fraternal) Grandfather:
(Fraternal) Grandmother:
Sister:
Sister:
Brother:
Brother:

Anything further to add (notes, comments, etc.):

Thank You !

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