Personal Health Story

Date_____

I. General Information

Name_____ _____ Phone (___) _____

Cell (___) _____ Email_____ Web site _____

Address (mailing) _____ Birth date_____

City, State, Zip_____

Work/occupation_____ Married / Single (circle)

Breast or bottle feed (circle), home or hospital birth (circle)

Approximate date of last medical exam_____

Are you presently under doctor's care? _____ Who? _____

For what_____

Do you currently take medications? _____ What? _____

Rx_____

Non RX_____

Are there any other healers, chiropractor, helpers, or therapies with which you are involved? ____

Who and/or what? _____

_____ How long? _____

II. Focus: What is your chief concern?_____

_____. Oneness is holistic living body, mind, spirit, family, finance, and community. How do you relate to this? What 2 areas do you desire to strengthen first?

_____ **Why?**

_____

List any current symptoms, problems, challenges

_____

_____

What are the three (3) factors in your life that seem most Important to your daily health and well-being._____

_____

III. Review of Body Systems/ Processes/ Symptoms

Please make **one check** mark **(√)** by the symptom if you have or had it **occasionally** in recent years. Mark **two checks** (√√) if the symptom **occurs often**, and **three checks** **(√√√)** if it is a **regular difficulty**.

Special considerations: Cardio pulmonary or Respiratory issues? Yes___ No___

___weight loss or gain
___urinary problems
___confusion
___bad breathe
___sore throats
___teeth/gum problem
___neck pains
___arm, shoulder, leg
___difficulty breathing
___fevers
___nightmares
___ringing in ears
___eyestrain
___sinus congestion
___abdominal pain s
___constipation
___aging rapidly
____sores in mouth
____muscle cramps
____itching
____blackouts

____mucous problem
____burning urination
____coated tongue
____muscle tension
____cough
____back pains
____bone or joint pain
____pain/discomfort
____shortness of breath
____heart palpitations
____breast lumps or pains
____nasal congestion
____sinus pressure
____difficult digestion
____diarrhea
____bedwetting
____tongue
____headaches
____skin rashes
____irregular bowel movements
___# of BM's daily

____hemorrhoids
____Fatigue
____bladder or kidney infection
____blood in urine
____leg swelling
____joint swelling
____bruise easily
____coughing
blood
____chest pains
____poor endurance
____double or blurry vision
____nosebleeds
____gas
____increased/decreased sexual desire
____nervousness
____cold hands &/or feet
____skin boils
____irregular bowel
____bloody or black BM

IV. Women's Reproductive/Womb Wellness

Date of last menstrual period_____

Are your periods regular? _____ frequency? _____

How many days is your flow? _____

Painful or symptomatic periods? _____

When was your last pap test? _____

Number of pregnancies_____ deliveries_____ abortions___

miscarriage_____ other_____

Do you practice birth control? _____ what form? _____

Check form you have practiced and write in the years practiced:

___BC pills_____ ___rhythm_____

___IUD_____ ___diaphragm_____

___astrological_____ ___mucus method_____

___abstinence_____ ___condoms_____

___chemical spermicidal_____

Reproductive/Prostate Wellness

Men – Prostate disease is every man's dis-ease. It is reported that after the age 40 the symptoms begin to show. Medical autopsy performed on men who die from other forms of dis-ease show prostate cancer present although it may not have been the cause of death.

Date of last **Prostate** exam_____

Name of doctor_____ Phone#_____

Results of last exam_____

Swelling? Yes____ or No____

Frequent / Painful Urination? Yes____ or No____

Are you on Rx Meds? Yes____ or No____
If yes please list_____

What other concerns do you or your spouse/mate have?

_____

V. Past Story

Do you have allergies? _____

If yes, to what medicines? _____

To what foods? _____

Or what in the environment_____

Have you taken medications regularly either prescribed or over-the-counter? _____

What and how often? _____

Do you take any vitamin, mineral, or herbal supplements? _____

Please list_____

Have you had any operations? _____ What type and when (year) _____

_____

Any major accidents or injuries? _____ What and when (year) _____

_____

Any major illnesses or hospitalizations? _____ What and when_____

_____

VI. Family Story

Do any illnesses *run* in your family? _____ What and who? _____

_____

Does anyone in your family suffer from chronic illness? _____

Who and What? _____

Please list your children (optional):

Name	Sex	Birthday
_____	_____	_____
_____	_____	_____
_____	_____	_____

VII. Eating and Exercise

Eating habits. How many times a day do you eat a full meal? _____

How much water do you drink a day in ounces? _____

Do you drink tap bottled home filtered? (circle)

What kind of beverages? _____

What herbal teas do you drink?

How many times do you snack? _____

What do you snack on? _____

What is your favorite?_____

What foods do you eat regularly for meals? _____

_____

How do you think about the nutritional benefit of foods you eat?

_____

_____

Are you over weight?_____ under weight?_____

Do you get regular exercise? _____ What kind? _____

How often? _____

Do you have a personal trainer or coach?_____

Oneness Wellness Lifestyles
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Start a Food Journal

PERSONAL NOTES: