

Pro Health Guide
A service of
Advanced Holistic Healing Arts

Client Name: _____ Date: _____
Please note that all information is strictly confidential

Client Information

Address: _____
City: _____ State _____ Zip _____
Phone: Home _____
Work _____ Cell _____
Email: _____
Date of birth: _____
Marital status: _____ # children: _____
Occupation: _____
Employer: _____
How did you hear about us? _____

Health Provider Information

Primary physician: _____
Other providers: _____

Emergency contact: _____
Day phone: _____ cell _____

Current Health Information

Reason for today's visit: _____

What types of treatment have you tried or are trying now? _____

What has been successful? _____

List medications, dosages and frequency, including herbs: _____

List medications, etc. taken in the last 6 months not currently taking: _____

Daily Activities/Lifestyle

Work: _____
Do you enjoy? _____ Hours/week _____
Home/Family: _____

Social/Recreational: _____

Stress Reduction: _____

Sleep: Hours per night _____

Exercise: _____
How often? _____

Meals: _____
What type of diet do you eat? _____

Frequency : Coffee _____ Water _____
Tobacco _____ Alcohol _____
Sodas _____ marijuana _____
other drugs _____

Health History

List and explain. Include dates.

Surgery: _____

Accidents: _____

Hospitalizations : _____

Mental Health : _____

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Symptoms/Condition Survey

Please circle the appropriate response
0=never 1=rarely 2=occasionally 3=frequently
4=always

Digestive

Low appetite _____
Loose stools _____
Gas/abdominal bloating _____
Fatigue after eating _____
Bruise easily _____
Ravenous appetite _____
Heartburn/acid reflux _____
Mouth sores _____
Belching or vomiting _____
Gums bleeding/swollen _____
Thirst _____
Crave sweets _____
Extreme feeling of fullness _____
Overeating _____
Nausea _____

Respiratory

Allergies _____
Asthma _____
Shortness of breath _____
Cough _____
Dry nose/mouth _____
Catch colds easily _____
Nasal discharge _____
Sinus congestion _____
History of bronchitis _____
Lung disease _____

Endocrine

Spontaneous sweating _____
Feeling cold _____
Feeling hot _____
Edema _____
Hair loss _____
Infertility _____

Dry skin _____
Frequent urination _____
PMS _____
Fatigue _____
Severe fatigue after exercise _____
Feel better after exercise _____
General Weakness _____
Swollen glands or nodes _____
Frequent infections _____
Thyroid dysfunction _____
Diabetes _____

MusculoSkeletal

Sore, cold or weak joints _____
Low back pain _____
Creaking/popping in joints _____
Stiffness _____
Rheumatoid arthritis _____
Osteoarthritis _____
Osteoporosis _____
Broken bones _____

Spinal disc problems _____
Lupus _____
TMJ _____
Spasms, Cramps _____

Neck, shoulder, arm pain _____
Hip, leg , foot pain _____
Wrist, hand pain _____
Joints give out _____

Cardiovascular

High blood pressure _____
High Cholesterol _____
High Triglycerides _____
Blood clots _____
Varicose veins _____
Hemorrhoids _____
Chest pain _____

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Tightness in chest _____
Irregular heart rate _____
Low blood pressure _____
Stroke _____
Lymphedema _____
Cold hands _____
Blue tinge to fingers _____
Pounding in ears _____
Dizzy when standing _____
Episodes of memory loss _____

Nervous
Head injury _____
Concussion _____
Dizziness _____
Tinnitus/ringing in ears _____
Confusion _____
Seizures _____
Memory loss _____
Mood swings _____
Shooting pains in extremities _____
Numbness, tingling _____
Change in coordination _____
Lack of coordination _____
Depression _____
Irritability/Anger _____
Foggy Thinking _____
Irrational thoughts/behavior _____
Anxiety _____
Restlessness _____
Insomnia _____
Disturbing dreams _____
Slurred speech _____
Difficulty finding words _____
Chronic Pain _____
Shingles _____
Neuro disorder _____
Migraines _____
Headaches _____

Urinary
Frequency _____
Burning _____
Dark Yellow _____
Profuse and clean _____
Pain with urination _____
Dribbling _____
Urinate when coughing, etc. _____

Bowel
Frequency of movement _____
Consistency _____
Mucous _____
Color _____
Undigested food in stool _____
Diarrhea _____
Pain _____

Reproductive
Currently pregnant _____
pregnancies _____ # live births _____
miscarriages _____ # abortions _____
Menopause _____ when _____
Regularity of cycle _____
Flow _____ Duration _____
Vaginal discharge _____
Recent pap smear _____
Results _____
Birth control methods _____

Pain or cramps _____
Breast cysts _____
Endometriosis _____
Uterine fibroids _____
Pain at ovulation _____

Last prostate exam _____
Results _____
Impotence _____

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Groin pain _____
Testicular pain _____
Difficult urination _____
Pain w/ ejaculation _____

Skin
Rashes _____
Warts _____
Fungal infections _____
Itching _____
Psoriasis _____
Dandruff _____
Dry, scaly _____
Scars _____

Cracked heels _____
Toenail fungus _____
Cracked, split or peeling nails _____
Tattoos _____

Piercings _____

Cancer/Tumors
Benign tumors _____

Cancer _____

Chemotherapy _____

Radiation _____

Hormone _____

Support group _____

General:
Saliva test for hormones _____
Results _____

I am committed to your health and well-being.
I recommend that you consult your physician regarding any condition identified on this form and in sessions.
I understand this consultation does not take the place of a physician consultation and diagnosis.

Consent for Care
I give my consent to my consultant to discuss any treatments with my physician and other health care providers.
Name _____
Signature _____

I understand that all decisions are up to me and that my consultant is offering options and suggestions that I can choose to explore. I will share any options I choose with my physician.
Signature _____

I have completed this form to the best of my knowledge and I will inform my consultant of any changes in my condition.
Signature _____

Contract for Care
I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my consultant and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised, or I am unable or unwilling to follow the program.

Signature _____
Date _____
Signature of parent or guardian if minor _____