Three Roses Wellness

Confidential Health History revised 9/2011

Please write or print clearly

Name: _____

Full Address: _____

Email address: _____ How often do you check email? _____

Telephone – Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____ Children? _____

Occupation: Hours of work per week:

Please list your main health concerns:

_____

When was the last time you felt really vibrant and well?

_____

Other current major life concerns?

_____

If you could wave a magic wand and change 2 things about your life right now, what exactly would they be?

_____

Any serious illness, hospitalization, injuries, and surgeries, either now or in your past?

_____

How is the health of your mother?

If deceased, relay illnesses. _____

How is the health of your father?

If deceased, relay illnesses. _____

What is your ancestry? _____ What blood type are you? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any ongoing sources of inflammation (e.g. eczema or other skin irritation, chronic post nasal drip, congestion, headaches, achy muscles/joints, swelling, pain, stiffness)? _____

This section for women only

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? _____ Please explain: _____

Birth control history: _____

Vaginal infections, reproductive concerns?

_____

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Do you struggle with Constipation, Diarrhea, Gas, Distension, Belching, or Bloating? Which? _____ Explain in detail: _____

Please list ALL supplements or medications you take (prescription or over-the-counter) and frequency?

Have you ever taken antibiotics more than a short course or two as a child? If so, when/how often? For what? And for how long?

Any remarkable exposure to toxins (e.g. current or childhood home, nearby industrial community, job, hobbies, travel, pesticides, heavy metals)?

What is the general status of your dental health/care?
Any troubling dental work or history of dental/oral infections? Dentures? Root canals?

How many silver/mercury fillings do you have? Other major dental work/issues beyond basic cleanings?

On a scale of 1 to 10, how would you rate your general energy level (1=lowest)?
To what do you attribute this energy level?

Any healers, helpers, pets or therapies with which you are involved? Please list:
What are your primary hobbies?

What role do sports and exercise play in your life?
What do you do to relax? How often?

What was your general health and well-being as a child?

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you have any known food allergies or sensitivities? _____

What percentage of your food is home-cooked? _____ What percentage is not? _____
Where do you get the rest from? _____

If you have a general philosophy, mindset or approach you use when _____

choosing foods, please describe it briefly. _____

Do you crave sugar, carbs, alcohol, coffee, cigarettes, other foods, or have any addictions?

_____

What two single changes do you most know you need to make in order to get healthier and reach your specific goals? _____

What specifically stands in the way of your making the healthier choices that you know would serve you the best? _____

Imagine what it will be like when you reach your specific health goals. What will this allow to happen in your life? Please give two specific benefits you are particularly excited about. _____

Many of our client's health situations are complex and have already been investigated by several other practitioners. Sometimes the most important ah-ha in uncovering wh you are struggling is an unexpected or unconventional concept. Intuitively, what do you feel is the most important pearl of information we need to understand about how or why your health is in the state that it is right now? _____

Anything else you would like to share?

Please also complete the symptom questionnaire on the following 2 pages.

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Symptom Questionnaire

Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two years. If multiple choices are given, please specify what applies in the comment column.

- ☐ Leave the score **blank** if you **Never** have the symptom.
- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild**.
- ☐ Use a **2** if you **Occasionally** have it and the effect is **Severe.**
- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
HEAD	Headache		
	Faintness		
	Dizziness		
	Insomnia		
NOSE	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
MOUTH	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore throat, hoarseness, or loss of voice		
	Swollen or discolored tongue, gums, or lips		
	Chronic tooth or gum pain or jaw pain. Which?		
	Canker sores		
SKIN	Acne		
	Hives or other allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
	Flushing or hot flashes		
	Frequently feel cold		
	Excessive sweating		
	Part of body frequently feeling numb. Which?		
HEART	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain		
LUNGS	Chest congestion		
	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing		
DIGESTION	Nausea or vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Intestinal or Stomach pain. Which?		
	Other pain in GI tract? Where?		

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(Page 2)
Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two years. If multiple choices are given, please specify what applies in the comment column.

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- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild**.
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- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
JOINTS AND MUSCLES	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Tremor or restless leg		
	Feeling of weakness or tiredness		
WEIGHT	Binge eating/drinking		
	Craving certain foods		
	Excessive weight		
	Compulsive eating		
	Water retention		
	Underweight		
ENERGY	Fatigue, sluggishness		
	Apathy, lethargy		
	Hyperactivity		
	Restlessness		
MIND	Poor memory		
	Confusion, poor comprehension		
	Poor concentration or focus		
	Poor physical coordination		
	Difficulty in making decisions		
	Stuttering or stammering		
	Learning disabilities		
MOOD	Mood swings		
	Anxiety, fear, nervousness		
	Anger, irritability, aggressiveness		
	Depression		
	Other mood challenges?		
OTHER	Frequent illness		
	Frequent or urgent urination		
	Inability to urinate or low urine flow		
	Low libido or other sexual dysfunction		
	Genital itch or discharge		
	Women: Breast fibroids		
	Women: Painful or tender breasts		
	Women: Uterine fibroids		
	Other		
	Other		
	Please tally your scores for this update here:		**Total Symptom Score**

Any further comments you wish to share?