Health And Well Being History Form

Name:	Email:
Address:	City, Prov, Postal code:
Phone:	Referred by:
Date:	Date of Birth:

Please answer the following questions honestly and to the best of your ability.

Describe the problem(s) for which you seek help. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, ect. Please describe and include approximate dates:

List the medications (including over the counter) you are presently taking:

What daily activities are you finding difficult or are limited because of your above complaints:

Have you ever had this problem before, if so when?

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

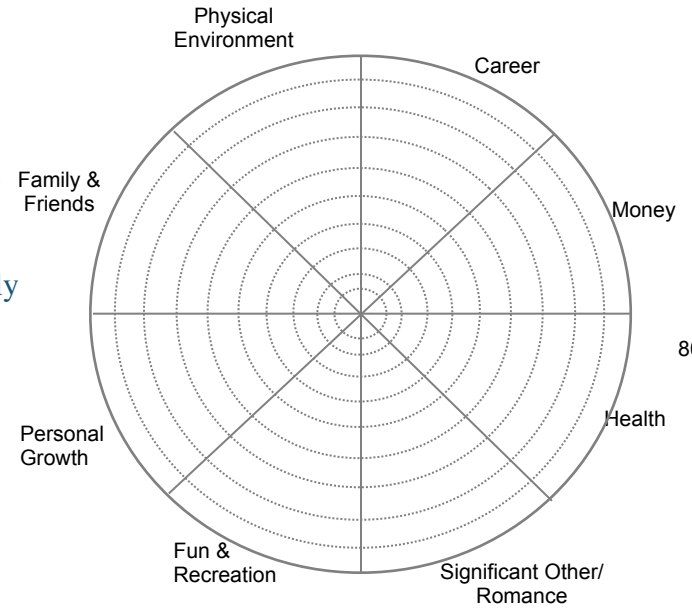
Please list any medical tests you have had within the past year:

Wheel of Balance

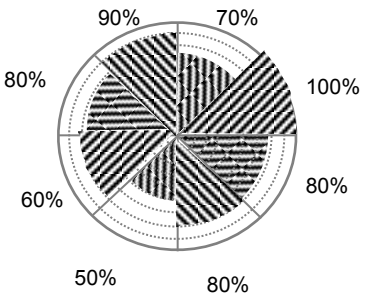
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the centre point radiating outwards.



Example:



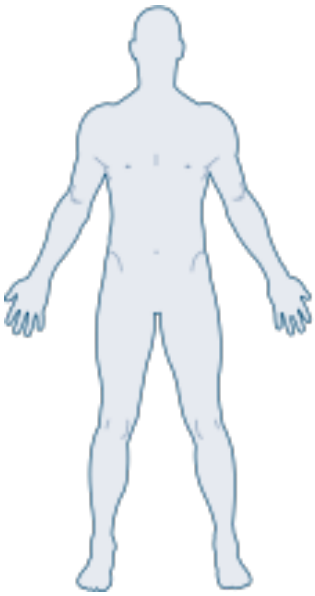
Is there one area of your life that you know you need to make a change in? If so, what area?
How can I best support you to make that change?

How much time do you have for yourself to relax and what do you do to relax, ie. hobbies, meditation, etc ?
Do you exercise? And if so, what kind and how often?
How many hours a night do you sleep? _____ Is your sleep restful? _____If not, please explain:

* Please list areas of pain and underline the level that best describes the level of discomfort on a scale of 1 to 10.	1. Slight awareness of discomfort. 2-3. Awareness of discomfort as an aggravation. 4-6. Pain is strong but you are still functional. 7-9. Pain is so strong you are unable to function normally. 10. You feel like you need to go to the emergency room.
1 2 3 4 5 <u>6</u> 7 8 9 10 example: neck	1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

* Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.



FRONT

Right Left

BACK

Left Right

COMMENTS:

* Please circle any of the following feelings you have experienced in the last few months.

Abused	Paranoid	Worried	Panic	Rejected	Easily irritated	Fearful
Criticized	Overwhelmed	Apprehensive	Intolerant	Despair	Anxious	Impatient
Overworked	Muddled	Agitated	Uncertainty	Helpless	Sad	Intimidated
Paralyzed	Persecuted	Uneasy	Aggravated	Hopeless	Grieving	Restless
Depressed	Guilty	Distress	Annoyed	Angry	Outraged	Nervous

Additional comments
Client Signature: