Lifesong Healing
Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be absolutely confidential. If you have any questions, please ask. Write on the back if more space is needed.

Date_____

Name_____Date of Birth_____ Age_____

Gender: ☐ Male ☐ Female Email Address _____

Address_____ City_____ State_____ Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Height_____Weight_____Occupation_____

Last School Grade Completed_____Difficulties in School _____

Family Physician_____ Last seen (date)_____ Referred by_____

Emergency Contact_____Emergency Contact Phone_____

Relationship status: ☐ Single ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed

Have you been treated with Homeopathy or other Alternative or Energy Healing Techniques in the past? ☐ Yes ☐ No

Explain:_____

_____

_____

What are the main problems you would like help with? When did they begin?_____

_____

_____

In what way do these problems interfere with your daily activities? _____

_____

_____

What diagnosis have you been given for these problems? By whom?_____

_____

_____

What kinds of treatment have you tried?_____

_____

_____

Current & Past Medical History: (Please give approximate dates)

☐ Cancer_____ ☐ High Blood Pressure_____ ☐ Thyroid Disease_____ ☐ Seizures_____

☐ Rheumatic Fever_____ ☐ Heart Disease_____ ☐ Hepatitis_____ ☐ Anemia_____

☐ Diabetes_____ ☐ HIV_____ ☐ Asthma/Pneumonia_____ ☐ Venereal Disease_____

Other (include chronic illnesses)_____

_____

_____

Surgeries (type of and date)_____

_____

_____

Significant physical trauma or hospitalizations (auto accidents, falls, concussions, etc.)_____

_____

_____

Have you used antibiotics in the past?_____ Have you received all recommended vaccinations?_____

Adverse Reactions?_____

Birth History (prolonged labor, forceps delivery, breech, etc.)_____

Allergies & Sensitivities (drugs, chemicals, foods, etc) & how do you react? _____

_____

_____

Significant emotional trauma_____

_____

_____

Family Medical History: (Please indicate which family member)

☐ Cancer_____ ☐ High Blood Pressure_____ ☐ Thyroid Disease_____

☐ Seizures_____ ☐ Heart Disease_____ ☐ Diabetes_____

☐ Hepatitis_____ ☐ Anemia_____ ☐ Asthma_____

☐ Other_____

Medicines taken within the last two months (prescription, over the counter, vitamins, herbs, etc.) _____

_____

Occupational Stress (chemical, physical, psychological, etc.)_____

_____

Do you have a regular exercise program? ☐ Yes ☐ No Please describe_____

_____

Have you ever been on a restricted diet? ☐ Yes ☐ No Please describe_____

_____

Please describe your average daily diet:

Morning_____

Afternoon_____

Evening_____

Snacks_____

Cravings_____

Do you smoke? ☐ Yes ☐ No How many packs per day?_____

How much coffee, tea or cola do you drink per week? Coffee_____ Tea_____ Cola_____

How much alcohol do you drink per week?_____

Please describe any use of drugs for non-medical purposes_____

Please Rate Your Satisfaction With the Following:

	Great	Good	Fair	Poor	Bad	Comments
Spouse						
Family						
Living Situation						
Diet						
Sex Life						
Self						
Work						
Exercise						
Spirituality						

Please check any symptoms you have had in the last three months:

General
__ Pain: Where:_____
Level (1 - 10)_____
__ Energy level (1 - 10)_____
__ Sudden energy drop
Time of day_____
__ Localized weakness
Where_____
__ Fatigue
__ Poor sleep
__ Sleep disorder
__ Fevers
__ Chills
__ Sweat easily
__ Night sweats
__ Bleed or bruise easily
__ Edema
Where?_____
__ Tremors
__ Poor balance
__ Weight Gain
__ Weight Loss

Head, Eyes, Ears, Nose & Throat
__ Dizziness
__ Migraines
__ Headaches?
When?_____
Where?_____
__ Facial Pain
__ Glasses
__ Poor vision
__ Night blindness
__ Blurry vision
__ Color Blindness
__ Blind field
__ Spots in front of eyes/floaters
__ Eye Pain
__ Eye Strain
__ Cataracts
__ Eye dryness
__ Excessive tearing
__ Discharge from eyes
__ Poor hearing
__ Ringing in ears
__ Earaches
__ Discharge from ear
__ Hearing aide
__ Nose Bleeds
__ Sinus congestion
__ Nasal drainage
__ Loss of consciousness
__ Grinding teeth
__ Teeth problems
__ Jaw clicks
__ Concussions
__ Recurrent sore throats
__ Hoarseness
__ Sore on lips or tongue
__ Other_____
_____
_____

Skin and Hair
__ Rashes
__ Itching
__ Change in hair or skin
__ Ulcerations
__ Eczema
__ Oozing or skin lesion
__ Hives
__ Pimples
__ Recent moles
__ Loss of hair
__ Dandruff
__ Foot fungus
__Other_____
_____
_____

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest discomfort/pain
__ Heart Palpitations
__ Cold hands or feet
__ Swelling of hands
__ Swelling of feet
__ Blood clots
__ Fainting
__Other_____
_____
_____

Respiratory
__ Allergies
__ Cough
__ Asthma/wheezing
__ Pain with a deep breath
__ Shortness of breath
__ Difficulty inhaling
__ Difficulty exhaling
__ Production of phlegm
What color?_____
__ Coughing blood
__ Pneumonia
__ Bronchitis
__ Other_____
_____
_____

Musculo-Skeletal
__ Neck pain
__ Shoulder pain
__ Back pain
__ Elbow pain
__ Hand/wrist pain
__ Hip pain
__ Knee pain
__ Foot/ankle pain
__ Muscle pain
__ Muscle weakness
__ Other_____
_____
_____

Urinary
__ Pain on urination
__ Urgency to urinate
__ Frequent urination
__ Profuse urination
__ Retention of urination
__ Blood in urine
__ Decrease in flow
__ Dribbling
__ Kidney stones
__ Do you wake up to urinate?
Yes___ No___
How often? _____
Color? _____
__Other_____
_____
_____

Diet/Gastrointestinal
__ Peculiar taste or smells
__ Strong thirst (cold or hot)
__ Thirst, no desire to drink
__ Change in appetite
__ Poor appetite
__ Bad Breath
__ Digestive Allergies
__ Nausea
__ Vomiting
__ Heartburn
__ Belching

__ Indigestion
__ Diarrhea
__ Constipation
__ Chronic laxative use
__ Blood in stools
__ Black stools
__ Abdominal pain or cramps
__ Abdomen tense or firm
__ Abdominal distention
__ Epigastric pain - better__ or worse__ with pressure
__ Gas
__ Rectal pain
__ Hemorrhoids
__Other_____
_____
_____

Psycho-emotional

__ Insomnia
__ Irritability
__ Loss of control/violence potential
__ Depression
__ Easily susceptible to stress
__ Anxiety
__ Substance abuse
__ Have you ever been treated for emotional problems?
Yes___ No___
__ Have you ever considered or attempted suicide?
Yes___ No___
__Other_____
_____
_____

Neurological

__ Seizures
__ Areas of numbness
__ Weakness
__ Concussion/loss of consciousness
__ Vertigo or dizziness
__ Lack of coordination
__ Loss of balance
__ Poor memory
__Other_____
_____
_____

Sexual/Genital

__ Changes in sexual drive
__ Sores on genitals
__ Pain in genital area
Do you consider your libido normal for your age? Yes__ No__
Too high__ Too low__

Female

__ Age of first menses _____
__ Days between menses _____
__ Number of Days _____
__ First day of last menses _____
__ Heavy periods __ Light periods
Color of blood_____
__ Painful periods
__ Irregular periods
__ Changes in body/psyche prior to menstruation? Describe_____
_____
_____
__ Clots
__ Menopause Age____Year____
__ Describe any problems_____
_____
__ Vaginal discharge
__ Bleeding after sex
__ Vaginal sores
__ Date of last pap smear _____
__ Breast lumps
__ Nipple discharge
__ Other_____
_____
_____

Pregnancy

Number of pregnancies_____
Number of births_____
Number of premature_____
Number of miscarriages_____
Number of abortions_____
Use of birth control? Yes___No___
What type?_____

Male

__ Impotence
__ Prostate problems
__ Premature ejaculation or wet dreams
__Other_____
_____
_____

Other Concerns_____
_____
_____

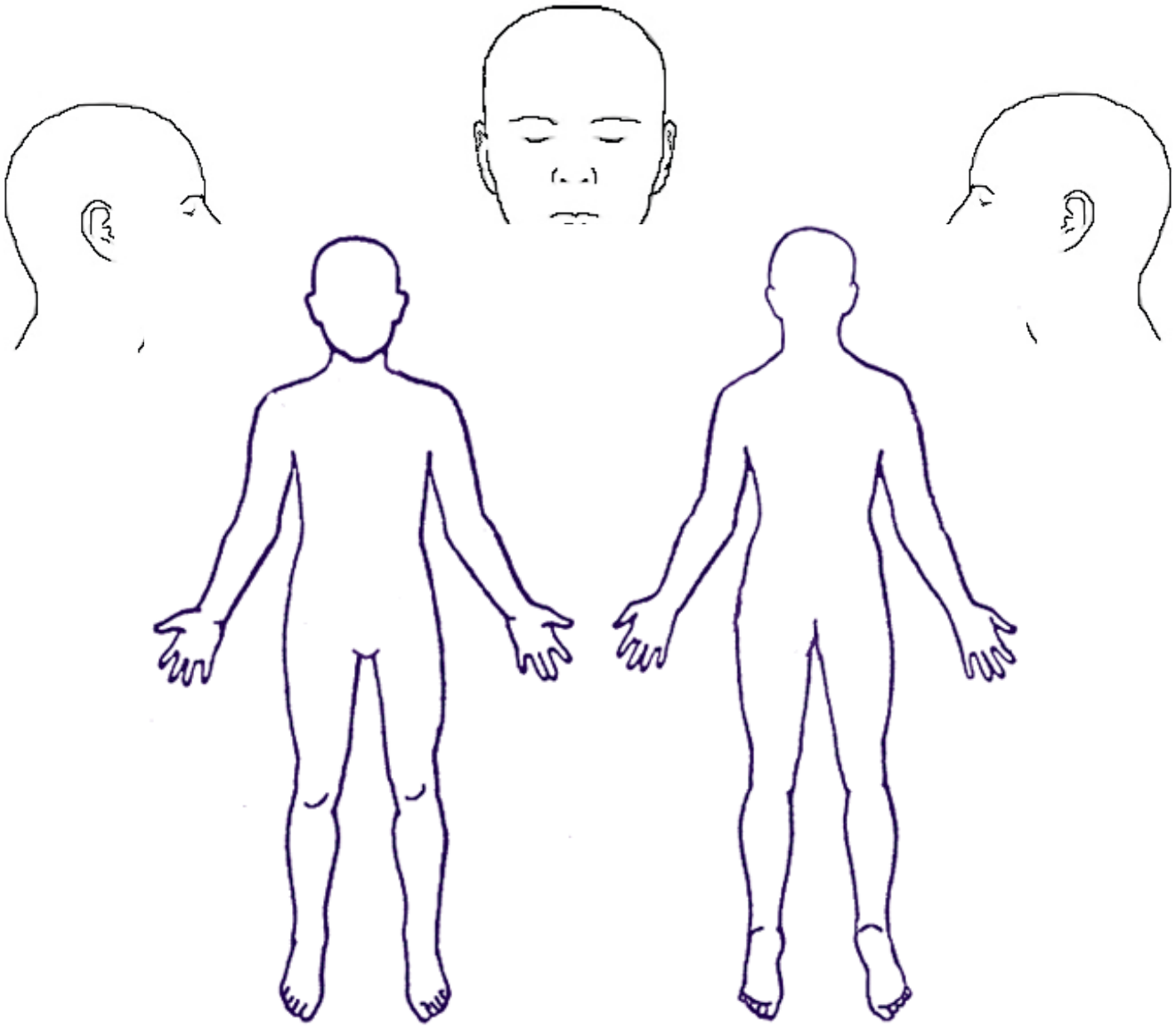
Please note the degree of severity of your main problem now:

No problem — Worst imaginable

Please note the greatest degree of severity of your main problem within the last week:

No problem — Worst imaginable

Indicate painful or distressed areas:



Front Back

Comments: (Please indicate any other problem you would like to discuss)_____

_____

_____

_____

_____

_____