**Health & Wellness Record** Date: _____

Name: _____ Date of Birth: _____ M / F
Address: _____ City: _____ PC _____
Phone: Hm: _____ Wk: _____ Cell: _____
Email: _____

How do you perceive your health NOW?: Good, Fair, Poor (please circle one)
What are you doing regularly to contribute to good health?

_____

What other therapies do you use? (ie Naturopath, Osteopath, Massage, Chiropractor, Reiki, Reflexology, Other: _____
Are you currently receiving doctor's care for specific condition/what? _____
Are you using any medications, including over the counter & vitamins? _____

_____

Last visit to doctor: _____ Do you have Now: Pain, Inflammation, Headache, Cold/Flu
Have you had any problems in any of the following areas? Please circle and give date if in past.

| | | |
|---|---|---|
| *Stomach/Bowel | *Stress | *Cancer |
| *Urinary | *Sleeplessness/Oversleeping | *MS |
| *Thyroid | *Headaches | *HIV/Aids |
| *Heart Condition | *Diabetes | *Allergies – please list |
| *Blood Pressure High/Low | *Liver/Spleen | _____ |
| *Tonsils/Adenoids/Throat infection | *Asthma | _____ |
| *Reproductive | *Skin Conditions | _____ |
| *Foot Conditions | *Joints (arthritis, etc.) | _____ |
| *Scar Tissue | *Varicose/Spider Veins | *Sinus |
| *Recent Surgery | *Internal Appliances/Prosthesis | Any chance you are |
| *Anxiety | *Chronic Fatigue/Fibromyalgia | Pregnant? _____ |
| *Aware of any existing blood clots | | |

Comments:

I am aware that a Complimentary Care Practitioner is **NOT** a medical doctor and cannot diagnose, prescribe or treat for any specific physical or mental condition.

I consent to receive treatment. Signature: _____