Personal History Form

Name:____Date:_____________
Address:____State:__________Zip:__________
Home Phone:_____________________________Cell Phone:_____________________________
Email:____Date of Birth:____________________
Age:_____ Marital Status:_____________________ Referred By:________________________

WHAT DO YOU WANT TO HEAL OR ACHIEVE? Also, please describe how long you have had each of the situations or concerns? ____
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____

Describe your present Treatment, Medications and Supplements: __________________________
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I understand that a Health Facilitator does not diagnose or treat, but teach individuals to gain and or maintain their health and well being. I, the under-signed, agree to take full responsibility for my health and what methods I employ.
Signed:____Date: ______________
Guardian name if signing for a minor:____

Please check Present and Past ailments of Yourself (Y), your Mother (M) and your Father (F)

___AIDS
___Alcohol dependence
___Allergies
___Alzheimer's Disease
___Anemia
___Anorexia
___Arthritis
___Athlete's Foot
___ADD / ADHD
___Autism
___Back Pain
___Bladder Problems
___Bladder Pressure
___Cancer
___Candida
___Cataracts
___Cholesterol – High
___Chronic Fatigue Syn.
___Colon Problems
___Cysts
___Depression
___Dermatitis
___Diabetes
___Diarrhea
___Dizziness
___Dyslexia
___Emphysema
___ Fibromyalgia
___Gingivitis
___Glaucoma
___Headaches
___Heart Problems
___Hiatal Hernia
___Hypoglycemia
___Incontinence
___Indigestion
___Insomnia
___Kidney Disorders
___Leukemia
___Liver Disorders
___Menopausal Problems
___Menstrual Problems
___Mononucleosis
___ Multiple sclerosis
___Osteoporosis
___Panic Attacks
___Vein Disorders
___Pneumonia
___Psoriasis
___PTSD
___Seizures
___Shingles
___Sinus Disorders
___Smoker
___Sore Throat (Chronic)
___Stroke
___Syphilis
___Tendonitis
___Thyroid Disorders
___TMJ
___Ulcers
___Vaginal Infections
___Water Retention
___Fast Weight Gain/Loss
___Other _______________
___Other _______________
___Other _______________
___Other _______________
___Other _______________