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| **bt_logo_color_100**  | **Wellness History Form**  |
| Name:  | Birthdate:  | Date: |
|  |
| Address:  |
| Phone: | Email: | Referred by? |
| **Current Wellness Concerns:**  |
| Describe issue(s) (physical, emotional, mental (belief system, traumatic memory), etc.) that brings you here, including current impact, frequency, initial onset, reoccurrence, and activities that are difficult or limited:  |
|  |
| **Overall Wellness History:** |
| Have you had any previous injuries, accidents, surgeries, etc? When? |
|  |
| Please list chronic illnesses you currently have or had (i.e. diabetes, heart disease, arthritis, fibromyalgia, BP, etc.): |
|  |
| If you currently suffer from an infectious disease, please provide detail: |
|  |
| Do you drink alcohol?  | Do you smoke?  | Chemical dependency? |
|  |
| How many hours per night do you sleep? Is it restful?  | How often do you relax/ hobby / meditate?  | Do you exercise? What activities? How often? |
| **Emotional Wellness:** |
| Please highlight which of the following you have experienced in the last few months: |
| AnxietyWorryFearPanic | DistressSadnessGriefUnable to Grieve | AnnoyanceEasily IrritatedIntoleranceAnger | RejectionDepressionHopelessParanoid | ImpatientConfusedBurdenedOverwhelmed |
|  |
| My family/relationship stress is (highlight response): [None] [Minimal] [Moderate] [Severe] Explain: |
| My work stress is (highlight): [None] [Minimal] [Moderate] [Severe] Explain: |
| My financial stress is (highlight): [None] [Minimal] [Moderate] [Severe] Explain: |
| My health stress is (highlight): [None] [Minimal] [Moderate] [Severe]  |
| Other stress (highlight): [None] [Minimal] [Moderate] [Severe] Explain: |
|  |

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| --- |
|  **Current Conditions:**  |
| BLANK if NOT Experienced or highlight; [1] Rarely (monthly or less); [2] Occasionally (< 1/wk); [3] Frequently (> 1/wk); [4] Constantly |
| *Digestion / Appetite / Weight* |
| Stomach/Intestinal Issue[1][2][3][4] | Appetite Big/Small [1] [2] [3] [4] | Nausea/vomiting [1] [2][3] [4] | Gall/Kidney stones [Yes] |
| Heartburn/Acid Reflux [1] [2] [3] [4] | Weight Gain/Loss [Yes] | Thyroid Problems [Yes] | Kidney Infections [Yes] |
| Gas/Belching [1] [2] [3] [4] | Soft/Brittle Nails [Yes]Anemia[Yes] | Food Allergies [Yes] Type: | Hemorrhoids [1][2][3][4] |
| *Respiration / Allergies* |  |  |  |
| Cough [1] [2] [3] [4] | Sinus Problems [1] [2] [3] [4] | Congestion [1] [2] [3] [4] | Pneumonia [Yes] |
| Bronchitis [Yes] When: | Allergies [1] [2] [3] [4] Type: | Wheezing [1] [2] [3] [4] | Asthma [Yes] |
| Fever/Chills [1] [2] [3] [4] | Weather Sensitive [1] [2] [3] [4] | Colds/Congestion [1] [2][3][4] | Emphysema [Yes] |
| *Heart / Circulation* |  |  |  |
| Chest Pain/Tightness [1] [2] [3] [4] | Heart Attack [Yes] When: | Heart Palpitation [1] [2] [3][4] | Edema [1] [2] [3] [4] |
| Shortness of Breath [1] [2] [3] [4] | Heart Disease [Yes] | Poor Circulation [Yes] | Easily Bruised [Yes] |
| Hypertension [Yes] Hypotension[Yes] | High Cholesterol [Yes] | Stroke [Yes] When: | Phlebitis [Yes] |
| *Elimination* |  |  |  |
| Loose Stool/Diarrhea [1] [2] [3] [4] | Blood in stool [1] [2] [3] [4] | Difficulty Urinating[1][2][3][4] | Incontinence [1][2][3] [4] |
| Constipation [1] [2] [3] [4] | Irritable bowels [1] [2] [3] [4] | Painful Urination [1] [2][3] [4] |  |
| *Head / Brain / Nervous System* |  |  |  |
| Head Injury/Nervous Disorder [Yes] | Numbness/Tingling [Yes] | Headache [1] [2] [3] [4] | Dev/Growth Problem[Yes] |
| Learning Disorder [Yes] Dyslexia[Yes] | Dizziness [1] [2] [3] [4] | Migrane [1] [2] [3] [4] | Epilepsy [Yes] |
| *Mobility / Weakness / Joints* |  |  |  |
| Limited Mobility [Yes] | Loss of Balance [1] [2] [3] [4] | Joint Swelling [1] [2] [3] [4] | Rheum Arthritis[Yes] |
| Physical Weakness [1] [2] [3] [4] | Multiple Sclerosis [Yes] | Difficulty Walking [1][2][3] [4] | Artificial Joints [Yes] |
| Poor Coordination [1] [2] [3] [4] | Muscular Dystrophy [Yes] | Osteoarthritis [Yes] | Fractures [Yes] |
| *Senses / Sense Areas* |  |  |  |
| Difficulty Swallowing [Yes] | Ear aches [1] [2] [3] [4] | Difficulty Speaking[1][2][3][4] | Dry Eyes [1] [2] [3] [4] |
| Poor sense of Taste [Yes] Smell [Yes] | Ringing in Ears [1] [2] [3] [4] | Excessive thirst [1] [2] [3] [4] | Watery Eyes [1] [2] [3][4] |
| Hearing Issue[Yes] Dental Issue[Yes] | TMJ Pain [1] [2] [3] [4] | Dry Mouth [1] [2] [3] [4] | Nose Bleeds [1] [2] [3][4] |
| *Sleep / Mental Ability* |  |  |  |
| Fatigue [1] [2] [3] [4]  | Unable to Focus [1] [2] [3] [4] | Difficulty Planning[1][2] [3][4] | Poor Memory [1 [2][3] [4] |
| Insomnia [1] [2] [3] [4] | Obsessive [1] [2] [3] [4] | Shaky [1] [2] [3] [4] | Restlessness [1][2][3] [4] |
| *Conditions* |  |  |  |
| Diabetes [Yes] | Herpes [Yes] | Candida [Yes] | Shingles [Yes] |
| Cancer [Yes] Type/Date: | Skin Condition [Yes] Type: | Hepatitis [Yes] | Infertility [Yes] |
|  |  |  |  |
| Men: | Prostate Problems [Yes] | Impotence [Yes] | Prostate Cancer [Yes] |
|  |  |  |  |
| Women: | Breast Lumps/Issues [Yes] | PMS [Yes] | Ovarian cysts [Yes]  |
| Menopause or Symptoms [Yes] | Irregular Periods [Yes]  | Endometriosis [Yes]  |
| *If any Current Condition noted above requires further detail, please add explanation below:* |
|  |
| **Physical Pain:** |
| Individually list body parts or body areas where physical pain exists (indicating left/right, front/back as applicable), and provide a pain scale rating from 1-10 for each, using the following scale:[1]-Slight discomfort; [2-3]–Discomfort is an aggravation; [4-6]–Strong pain, able to function; [7-9]–Strong pain, limited function; [10]–Emergency room! |
|  |