

HEALING UNLEASHED, HEALTH SERVICES, LLC
 3609 S. Wadsworth Blvd., Ste 132
 Lakewood, CO 80235
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HEALTH INVENTORY

This information is confidential and will only be released with your signed consent.

Name: _____ **Today's Date:** _____
Address: _____ **Birthdate:** _____
City: _____ **ST:** ____ **Zip:** _____ **Age:** _____ **Sex:** F M
Phone: Wk: _____ **Hm:** _____ **Height:** ___ **Weight:** ___
Cell Phone: _____ **Legal Status:** S M D Sep W
E-mail Address: _____ **Living Situation:** _____
Emergency Contact: Name: _____ **Education: (yrs. Completed)** _____
Phone: _____ **Relationship:** _____ **Elem:** ___ **HS:** ___ **Coll:** ___ **Voc:** ___ **Prof:** ___
If under 18, parents name/address: _____

Referred by: _____ **Occupation:** _____
Address: _____ **Retired: Yes** ___ **No** ___
Family Physician: _____ **Holistic Practioner** _____
Address: _____ **Address:** _____

FAMILY HISTORY

____ Check if family history is unknown

	Age	Problems (If deceased, cause of death)	Children	Age	Problems...
Father					
Mother					
Siblings:					

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles)

YES	Condition	Relationship	YES	Condition	Relationship
	Alcohol/Drug problem			High Blood Pressure	
	Allergy/Asthma			High Cholesterol	
	Anemia			Kidney Disease	
	Arteriosclerosis			Liver Disease	
	Arthritis			Mental Illness	
	Binge Eating/Bulimia			Obesity	
	Bleeding problem			Stroke	
	Cancer			Suicide	
	Diabetes			Thyroid Disease	
	Epilepsy/Seizure			Tuberculosis	
	Heart Disease			Ulcers	
	Skin Disease			Syphilis	
	AIDS			Gonorrhea	

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: List all Surgeries and approximate Dates

Other Hospitalizations and Dates

Broken Bones, Traumatic or Spinal Injuries and Dates
Include all Car Accidents or Concussions

Major Complaints and Duration
 Example: *High Blood Pressure – 10 years*

PAST HISTORY

YES	Condition	When	YES	Condition	When	YES	Condition	When
	Acne			Fibrocystic Breasts			Nightmares-frequent	
	AIDS			Fibroids			Overweight (20 lbs)	
	Alcohol/Drug problems			Gallbladder problems			Pelvic Infection	
	Allergies			Glasses/Contacts			Peptic Ulcer	
	Amalgams/Silver fillings			Glaucoma			Periodontal Disease	
	Anemia			Gonorrhea			Phlebitis	
	Antibiotics-more than 1x/year			Gout			Pneumonia	
	Anxiety			Hay Fever			Premenstrual Tension	
	Asthma			Hearing problem			Prostate problems	
	Back Pain/Strain			Heart Attack			Psychotherapy	
	Binge Eating			Heart Failure			Reactions to Vaccines	
	Bladder Infections			Heart problem			Rheumatic Fever	
	Blood Clots			Hemorrhoids			Root Canal	
	Breast Fed			Hepatitis			Scarlet Fever	
	Breast Lump			Herpes			Sexually Transmitted Disease	
	Bronchitis			Hiatal hernia			Sinusitis	
	Bulimia			High Blood Pressure			Skin problems	
	Cancer			High Cholesterol / Triglycerides			Sleep Disorder	
	Cataract			Histoplasmosis			Stroke	
	Chemical Sensitivity			Hives			Suicide Attempt	
	Chicken Pox			Hypoglycemia			Syphilis	
	Chronic Fatigue			Infectious Mono			Taken Steroids (Prednisone/Cortisone)	
	Coccidiomycosis			Insomnia			Thyroid problems	
	Colds-frequent			Kidney Infection			Tonsillitis	
	Colitis			Kidney problems			Tooth problems	
	Congenital Defect			Kidney Stones			Tuberculosis	
	Counseling			Liver Disease			Urine problems	
	Depression			Measles			Vaginitis	
	Diabetes			Menstrual problems			Vision problems	
	Ear Infection			Mental Illness			Other problems	
	Eczema			Migraine				
	Endometriosis			Mumps				
	Epilepsy			Nervous Conditions				
	Epstein Barr			Neurological problems				

PERSONAL HISTORY

Current Medications

(List all Prescriptions and Non-prescriptions)

Vitamins and Mineral Supplements

(Types and Dosage)

Allergies

I am allergic to the following medications:

Known allergies to Foods, Chemicals, Inhalants, etc.
(i.e.: Pollens, Animals, etc.)

Lifestyle

(List your favorite Foods or Cravings.)

Check all that apply:

_____ I often eat seconds

To control my weight, I have used:

- _____ Diet pills _____ Diuretics (water pills)
- _____ Enemas _____ Laxatives
- _____ Fasting longer than 1 day _____ Self-induced vomiting
- _____ Healthy Diet _____ Exercise

Other: _____

I am now or have been a smoker: ___ Yes ___ No

of Years: _____ How much: _____

What I smoke now: _____

When I quit: _____

My estimated use of:

- Coffee: _____ Cups/Day Decaf: _____ Cups/Day
- Tea: _____ Cups/Day Soda: _____ Cups/Day

I drink: _____ Beer _____ Wine _____ 'Hard' Liquor

I consider myself a: _____ non-drinker _____ social drinker
_____ heavy drinker _____ alcoholic _____ recovering alcoholic

I use: _____ Marijuana _____ Other Drugs: _____

I think I need counseling or medical care to help me
control the use of: _____ Alcohol _____ Tobacco
_____ Food _____ Drugs

I usually eat: (Check all that apply)

- _____ White bread _____ Whole Grain bread
- _____ Commercial Wheat bread

Vegetables: _____ Fresh _____ Frozen _____ Canned

Fruits: _____ Fresh _____ Frozen _____ Canned

I usually eat my:

Vegetables: _____ Raw _____ Steamed _____ Boiled
_____ Sautéed

Meat & Fish:: _____ Pan Fried _____ Deep Fried _____
_____ Baked _____ Broiled

I usually eat Beef or Pork: _____ At least once/day
_____ 5 times/week _____ Less than 3 times/week _____ Never

My use of Salt: _____ None added _____ Light
_____ Moderate _____ Heavy

I eat refined Sugar: _____ Yes _____ No

The water I drink: _____ City _____ Well _____ Spring
_____ Distilled

of Glasses/Day: _____

I would like Nutritional Counseling: _ Yes ___ No

I have participated in an Exercise Program: ___ Yes ___ No
I Exercise on a Regular Basis: ___ Yes ___ No
I think this is Enough Exercise: ___ Yes ___ No
I would like to do More Exercise: ___ Yes ___ No

I find my work: ___ Too Demanding ___ Boring

My Sex Life is Satisfactory: ___ Yes ___ No

I do the following for Relaxation/Recreation:

Activity	Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

My last Physical Exam was: _____

I sleep well: ___ Yes ___ No ___ Hrs.

I worry about: ___ Money ___ Family Life ___ Job
___ Relationships ___ Other: _____

I currently see a psychotherapist or other mental health professional: ___ Yes ___ No

I have been arrested: ___ Yes ___ No

Abuse I have been a victim of: ___ Physical
___ Sexual ___ Emotional

I have been in the Military: ___ Yes ___ No

My Spiritual Life is Satisfactory: ___ Yes ___ No

I am currently involved in a regular Spiritual Program: ___ Yes ___ No

LIFE CHANGES

In the last 12 months, what changes have occurred in your:

Personal Life

Family Life

Social Life

Work Life

Sex Life

How do you feel when you wake up in the morning? What makes you want to get up in the morning?

What are your health goals?

What is the most important thing in your life?

REVIEW OF SYSTEMS

Answer 'Yes' if you have had these symptoms in the last 6 months.

YES	Condition	YES	Condition	YES	Condition
	Chronic Fatigue		Loss of Hearing		Difficulty Swallowing
	Mood Swings		Ringling/Buzzing in Ears		Pain/Discomfort when Eating
	Chronic Depression		Sinus trouble		Bad Teeth
	Trembling Episodes		Nosebleed		Belching
	Light-Headedness		Sore Throat		Coating on Tongue
	Food Craving		Hoarseness		Pain Relieved by Eating
	Frequent Infections		Change in Voice		Nausea/Vomiting
	Night Sweats		Dental problem		Trouble with Fried Foods
	Swollen Glands		Dry Mouth		Bloating of Abdomen
	Skin Rash		Excessive Salivation		Bowel Gas
	Chills/Fever		Bleeding Gums		Diarrhea
	Change in Skin/Nails		Mouth Breather		Constipation
	Change in Hair or Mole		Chronic Cough		Black Stool
	Abnormal Bleeding/Bruising		Bloody/Yellow Sputum		Clay-Colored Stool
	Unusual Hair Loss/Growth		Shortness of Breath		Mucous in Stool
	Irritability		Shortness of Breath with Exertion		Hemorrhoids
	Restlessness		Shortness of Breath at Night		Rectal Bleeding
	Headaches		Bronchitis		Abdominal Pain
	Dizziness		Chest Pain with Breathing		Change in Diet
	Balance problem		High Blood Pressure		Pain/Burning during Urination
	Head Injury		Chest Pain or Pressure		Frequent Urination
	Seizure/Convulsion		at Rest		Urination at Night
	Poor Memory		with Exertion		Blood in Urine
	Difficulty Concentrating		with Stress		Foul Odor to Urine
	Fainting		with Eating		Low Back Pain
	Weakness		down Left Arm, Neck or Back		Loss of Control of Urine
	Numbness/Tingling		accompanied by Nausea,		
	Blurred Vision		Sweating, and/or Anxiety		Muscle Pain:
	Double Vision		Irregular Heartbeat		Where:
	Loss of any Vision		Skip beats		
	Halos around Lights		Palpitations		Muscle Weakness:
	Excessive Tearing/Itching of Eyes		Fast Heartbeat		Where:
	Eye Pain		Heart Murmur		
	Dark Circles under Eyes		Swelling Feet/Legs		Joint Pain:
	Date of Last Eye Exam: _____		Cold Hands/Feet		Where:
			Leg Cramps at Night		
			Pain or Fatigue in Legs with Exercise		Joint Pain aggravated by Motion
			Burning in Feet		Joint Pain relieved by Motion
			Sore Legs/Feet		Swollen Joints
			Color Change of Legs/Arms		Stiff Joints

WOMEN

Last Menstruation Period: _____
 Age began Menstruation: _____
 Age at Menopause: _____
 Number of Pregnancies: _____
 Number of Live Births: _____
 Number of Abortions/Miscarriages: _____

	Complication of Pregnancy
	Used Birth Control Pills
	Used IUD Type: _____
	Usual Length of Cycle: _____
	Usual Length of Period: _____
	Change in Cycle

	Spotting Between Periods
	Discomfort with Periods
	Premenstrual Tension
	Vaginal Discharge
	Painful Intercourse
	Vaginal Itching
	Self Breast Examinations
	Self Vaginal Examinations
	Would you like to Learn the Self Exam?
	Problem with Sexual Function
	Lump in Breast
	Abnormal Pap Smear
	Infertility

Date of Last Pap Smear: _____

MEN

	Enlarged Prostate
	Decreased Urine Stream
	Dribbling after Urination
	Pus or Drainage from Penis
	Genital Swelling/Rash
	Problem with Sexual Function

FOR OUR MEDICAL MASSAGE CLIENTS

Muscular-skeletal System:

How do you use your body at work? (sit, stand, walk, lift, carry, etc. _____)

Are you trained in, & do you practice the following on a regular basis?

- | | | |
|--|--|--|
| <input type="checkbox"/> Posture Awareness | <input type="checkbox"/> Yoga/Stretching Program | <input type="checkbox"/> Corrective Exercise |
| <input type="checkbox"/> Pilates | <input type="checkbox"/> Cardiovascular Fitness | <input type="checkbox"/> Core Exercise |
| <input type="checkbox"/> Breathwork | <input type="checkbox"/> Strength Training | |

Describe your exercise, sports, fitness & physical recreation program (golf, hiking, exercise equipment, swimming, tennis, etc.):

Activity:	Frequency:
Activity:	Frequency:
Activity:	Frequency:
Activity:	Frequency:

List any sports in which you competed or participated long-term (include childhood & as an adult):

Check off any of the following bone, joint and soft tissue diseases, which you have been diagnosed with:

- | | | |
|---|---|---|
| <input type="checkbox"/> Kyphosis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Hammer toe | <input type="checkbox"/> Bursitis |
| <input type="checkbox"/> Lordosis | <input type="checkbox"/> Congenital hip dysplasia | <input type="checkbox"/> Tennis Elbow |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Runner's Knee |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Spondylolisthesis | <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Stenosis | <input type="checkbox"/> Thoracic Outlet Syndrome |
| <input type="checkbox"/> Paget's disease | <input type="checkbox"/> Degenerative Joint Disease | <input type="checkbox"/> Piriformis Syndrome |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Degenerative Disk Disease | |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Fibromyalgia | |

YOUR CHIEF COMPLAINT

TELL US ABOUT THE PAIN AND RESTRICTION THAT TROUBLES YOU MOST:

I feel pain in my _____

Circle how the pain feels: dull ache deep ache throb numb tingle sharp spasm radiates other

Circle how frequently the pain occurs: constant frequent occasional

Only with certain activity (describe) _____

Have you ever had this or a similar pain problem before? If yes, give details: _____

Date of first onset of pain: _____

Describe how the pain problem progressed (example: it started with an ache in my shoulder & quickly became severe pain in my shoulder & upper arm with numbness in my 3rd & 4th fingers)

Circle what makes the pain worse: sitting lifting twisting standing walking other _____

Circle what make the pain better: resting ice massage moist heat other _____

List over-the-counter & prescription drugs you are using for this pain: _____

Has a medical doctor given you a diagnosis for this pain? _____

What improvement or healing do you hope to realize from medical massage? _____

TELL US ABOUT THE SECOND MOST PAINFUL AREA:

I feel pain in my _____

Circle how the pain feels: dull ache deep ache throb numb tingle sharp spasm radiates other

Circle how frequently the pain occurs: constant frequent occasional

Only with certain activity (describe) _____

Have you ever had this or a similar pain problem before? If yes, give details: _____

Date of first onset of pain: _____

Describe how the pain problem progressed (example: it started with an ache in my shoulder & quickly became severe pain in my shoulder & upper arm with numbness in my 3rd & 4th fingers)

Circle what makes the pain worse: sitting lifting twisting standing walking other _____

Circle what make the pain better: resting ice massage moist heat other _____

List over-the-counter & prescription drugs you are using for this pain: _____

Has a medical doctor given you a diagnosis for this pain? _____

What improvement or healing do you hope to realize from medical massage? _____

THANK YOU FOR CHOOSING "HEALING UNLEASHED HEALTH SERVICES, LLC." OUR GOAL IS TO PROVIDE YOU AND YOUR FAMILY WITH THE BEST, GENTLE AND SAFE THERAPIES TO ASSIST YOU IN HEALING AND GAINING GREATER HEALTH.

WE GREATLY APPRECIATE YOUR REFERRALS!