Health and Well Being History Form

Name:	Home Phone:
Address:	Work Phone:
Email:	Cell Phone:
Date of Birth:	Referred by:
Occupation:	

Describe the problems you seek help for. Please include dates when each problem occurred:

Past medical history (previous injuries, accidents, surgeries, etc.) Please describe and include approximate dates:

List of medications you are presently taking:

What daily activities are you finding difficult or are limited to because of your above complaints:

Have you ever had this problem before and if so, when?

What are your goals from these sessions?

Please list other healthcare professionals you are seeing for your problems?

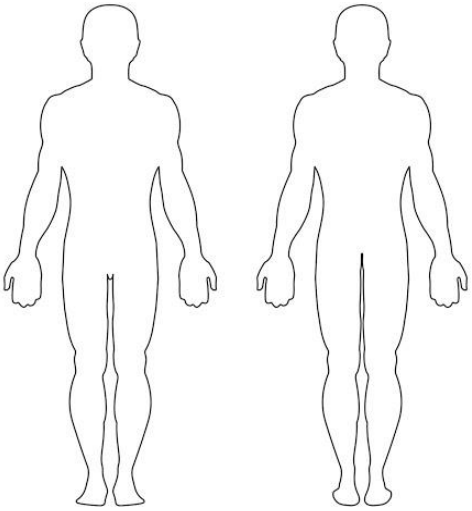
Please list any medical tests you have had within the past year:

Please circle any of the following feelings you have experienced in the last few months:

Abused	Paranoid	Unable to Grieve	Panic	Criticized	Overworked	Intolerant
Paralyzed	Aggravated	Overwhelmed	Sad	Uneasy	Muddled	Depressed
Agitated	Distress	Apprehensive	Guilty	Annoyed	Uncertainty	Fearful
Rejected	Despair	Easily Irritated	Andry	Anxious	Persecuted	Impatient
Helpless	Hopeless	Intimidated	Nervous	Restless	Grieving	Worried

Please circle what best describes your level of stress for the listings below:

My family stress is:	None	Minimal	Moderate	Severe
My relationship stress is:	None	Minimal	Moderate	Severe
My work stress is:	None	Minimal	Moderate	Severe
My health stress is:	None	Minimal	Moderate	Severe
Other stress is:	None	Minimal	Moderate	Severe

How much time do you have to relax and what do you do to relax? ie. Hobbies, reading, sports	
Do you exercise? If so, what kind and how often?	
How many hours do you sleep? Is your sleep restful? If no, please explain.	
Please list areas of pain and circle what best describes the level of discomfort on a scale of 1 to 10:	
1 2 3 4 5 6 7 8 9 10 example: neck	1: Slight awareness of discomfort
1 2 3 4 5 6 7 8 9 10	2-3: Awareness of discomfort as an aggravation
1 2 3 4 5 6 7 8 9 10	4-6: Pain is strong but you are still functional
1 2 3 4 5 6 7 8 9 10	7-9: Pain is so strong you are unable to function
1 2 3 4 5 6 7 8 9 10	10: You feel you need to go to the emergency room
Please share the areas of pain or discomfort on the body diagram and make any comments on the side:	
	
Date:	Signature: