



CALM HealthWorks

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Health History Form

Date _____ Name _____

Street Address _____ City: _____ Zip: _____

Phone home: _____ work: _____ cell: _____

Birthday _____ Referred by _____

Age _____ Sex _____ Weight _____ Desired Weight _____

Height _____ email: _____

Number and Ages of children _____

1st Major symptom:

Other Health Issues:

Date started:

2nd major symptom:

Date started:

3rd major symptom:

Date started:

List accidents and operations:

List "family" illnesses: (example: high blood pressure on your mother's side and heart disease on your father's side).

List dental issues including # of cavities, root canals & crowns:

Bowel history (color, size, frequency, shape, texture):

Describe your typical diet. (Include amounts, brand names if known, method of cooking (fry, boil, steam, etc). Please give several options for each meal and include your least healthiest meal to your healthiest.

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Give a brief overview of pharmaceutical drugs (lifetime use), including duration and what it was addressing. Include antibiotics, over-the-counter drugs and prescription:

List traumatic or shocking events throughout your lifetime and approximate dates:

Describe the quantity and frequency in which you use the following:

Alcohol:

Recreational Drugs:

Tobacco:

Give an overview of supplements (vitamins, minerals, herbs, homeopathy, etc):

What do you do for work?

What do you do to relieve pain?

What do you do for exercise?

List previous illnesses with approximate dates, including childhood ones:

List any allergies:

List any cravings:

On a scale from 1 to 10 (low to high) assign a number to the amount of stress you experience in your daily life.

List your health goals:

For All Clients:

Please know that the information you receive in your consultation is not medical advice; instead, it is a sharing of knowledge and information from the education, research, training, and experience of the practitioners at CALM HealthWorks. This is not intended to replace the relationship with your primary health care providers.

We encourage you to be open to new information on the effectiveness of the fundamental role of diet, exercise, supplementation, stress management and emotional, energetic, and mental work. We encourage you to make your own health decisions based upon your research and in partnership with your primary health care providers, ND, MD or otherwise.

I, the undersigned, reserve the right to seek or ask nutrition or wellness care advice, counsel, recommendations, suggestions, assessments, evaluations, test and/or treatments, regimens or modalities from the nutritionist or doctor or health care provider of my choice for any health reason or purpose.

I acknowledge that the information and service provided at CALM HealthWorks are not used to prescribe, recommend, diagnose, or treat a health problem or disease. It is not a substitute for medical care. I agree to hold harmless any and all personnel of CALM HealthWorks, LLC from any present or future liability.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Cancellation & Refund Policy:

Cancellations or changes to scheduled appointments must be made 24 hours in advance of the scheduled appointment. Otherwise, you will be billed for the cost of service as a cancellation charge. Any check returned for insufficient funds will be subject to a \$35.00 processing fee. If you are calling after business hours, please leave a message on our voicemail indicating your appointment cancellation. The same charge applies for missing an appointment. All payments for services are nonrefundable. Thank you.

Signature: _____ **Date:** _____