

# GENERAL HEALTH HISTORY

Name \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Other phone \_\_\_\_\_

E-mail \_\_\_\_\_ Occupation \_\_\_\_\_

Please describe any accidents, major illnesses, surgery or complaints that you have had in the past. Dates are approximate. Let me know what remedy you have used to deal with this condition.

Date	Accident / Illness / Surgery / Complaints	Remedy

Are you currently seeing a  Medical Professional  LMT  Other \_\_\_\_\_

What condition are you being treated for? \_\_\_\_\_

## General Health History

Please mark all that currently apply or have in the past year

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="radio"/> Skin disorders</li> <li><input type="radio"/> Rashes</li> <li><input type="radio"/> Allergies</li> <li><input type="radio"/> Arthritis</li> <li><input type="radio"/> Joint Problems</li> <li><input type="radio"/> Varicose veins</li> <li><input type="radio"/> Heart problems</li> <li><input type="radio"/> Circulatory problems</li> <li><input type="radio"/> High blood pressure</li> <li><input type="radio"/> Hypoglycemia</li> <li><input type="radio"/> Diabetes</li> <li><input type="radio"/> Epilepsy</li> <li><input type="radio"/> Cancer</li> <li><input type="radio"/> Emotional difficulties</li> <li><input type="radio"/> ADD / ADHD</li> </ul> | <ul style="list-style-type: none"> <li><input type="radio"/> Behavioral difficulties</li> <li><input type="radio"/> Hepatitis</li> <li><input type="radio"/> TMJ (jaw pain or dislocation)</li> <li><input type="radio"/> Sinusitis</li> <li><input type="radio"/> Whiplash</li> <li><input type="radio"/> Headaches</li> <li><input type="radio"/> Migraines</li> <li><input type="radio"/> Female cycle imbalances</li> <li><input type="radio"/> Currently under medication<br/>which _____</li> <li><input type="radio"/> Currently pregnant<br/>which month _____</li> <li><input type="radio"/> Irritable bowl syndrome</li> <li><input type="radio"/> Ulcers</li> <li><input type="radio"/> Herniated disk – which? _____</li> </ul> |
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**Please list the situations, people and circumstances  
that you consciously experience as stressful**

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**General Difficulties**  
Please mark and explain

- Back or neck \_\_\_\_\_
- Coordination \_\_\_\_\_
- Ears    Eyes (contacts/glasses etc.)    Nose    Throat  
explain \_\_\_\_\_
- Energy level (too high or low) \_\_\_\_\_
- General aches or pains \_\_\_\_\_
- Food related issues \_\_\_\_\_
- Posture \_\_\_\_\_
- Skin \_\_\_\_\_
- Stomach    Digestion \_\_\_\_\_
- Constipation    Diarrhea \_\_\_\_\_
- Reading    Writing    Spelling \_\_\_\_\_
- Math    Calculations \_\_\_\_\_
- Concentration    Memory \_\_\_\_\_
- Interpersonal    Intrapersonal \_\_\_\_\_

**Long Term Goals for Self Improvement**  
(Physical, Mental, Emotional, Spiritual)

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**In the interest of better understanding the extent of my outreach, please mark the  
resource that first introduced you to my services:**

- Yellow Pages
- TFHK Association
- Edu-K Foundation
- 3-in-1 Concepts
- Lucia's Course Catalog
- ConneXions website / newspaper
- VibrationalEnergyHealing.com
- Friend / relative \_\_\_\_\_

**Facilitator Observations**  
(Please do not mark in this area)

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