FIERY MAPLE
WHOLISTIC HEALING

HEALTH INVENTORY

Answering the questions as thoroughly as possible will provide insight into your current health status. Pulling all this information together helps one to see patterns and tendencies. The information is confidential and will not be released to any person without your request.

Name: _____ Age _____ Birth date _____

Address: _____

Home Phone: _____ Work Phone _____

Height: _____ Weight: _____ 1 year ago _____ 5 years ago_____

Occupation:_____ Full time_____ or Part time_____

Living situation: Alone Friends Partner Spouse Parents Children Pets

Names and ages of those living with you:

What are your major health concerns and intentions for your visit today?

Please list any other health care providers or consultants you are currently working with:

Would you like any of them to receive a copy of your recommendations?

Please list all herbs, vitamins, and dietary supplements you currently take, citing brand name whenever possible: (use additional space on back if needed.

PRODUCT	DOSAGE	FREQUENCY (# per/ DAY)

List all medications you are currently taking (including aspirin, antacids, etc.) indicating whether they are over the counter (OTC) or Prescribed (P). Use additional space on back if needed.

PRODUCT	OTC OR P?	DOSAGE	FREQUENCY (# per/ DAY)

List all medications, herbs, etc., to which you have a known allergy.

DIETARY INFORMATION

Describe below your typical meals. Please be as specific as possible. For example, instead of "oil" list type of oil, such as olive, corn, etc. Instead of "bread" list whether white or whole grain, etc. Instead of "vegetables" list the type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include all beverages, type and quantity (two cups of coffee, one glass of orange juice, etc.)

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Daily water consumption (number of glasses/day):

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.):

Please list any known food allergies/sensitivities:

FOOD	DESCRIBE REACTION

FAMILY HISTORY

Please describe any relevant or major health related issues: (alcoholism, high blood pressure, cancer, diabetes, heart disease, psychiatric illness, osteoporosis, other addictions, other illnesses)

Mother:

Father:

Sister(s):

Brother(s):

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Other family members with pertinent issues, or recurring family health trends:

PAST HEALTH PROBLEMS

List all major health problems including any operations.

PROBLEM	YEAR

GENERAL HEALTH

Cardiovascular

___High blood pressure
___Low blood pressure
___Pain in heart
___Poor circulation
___Swelling
___Stroke/murmur

Respiratory

___Chest pain
___Difficulty breathing
___Cough
___Tuberculosis
___Congestion
___Wheezing
___Asthma
___Coughing up blood

Eyes, Ears, Nose and Throat

___Failing vision
___Sinus congestion
___Hearing loss

General

___Fatigue
___Excessive thirst

___Difficulty sleeping

Skin

___Boils
___Bruises
___Dryness
___Itching
___Varicose veins
___Skin eruptions

Urinary/Kidney

___Excessive urination
___Water retention
___Burning urine
___Kidney stones
___Lower back pain
___Dark circles/under eyes
___Itchy ears/eyes
___Blood in urine

___Ear aches
___Hay fever
___Sore throat
___Canker sores

___Night sweats
___Loss of appetite

___Frequently colder or warmer than others

Muscles/Joints

___Backache
___Broken bones
___Mobility
___Arthritis
___Bursitis
___Weakness

Gastro-Intestinal

___Belching
___Colitis
___Constipation
___Abdominal pain
___Liver problems
___Gall stones
___Ulcers
___Transit time

___Eye pains
___Sinus infection
___Tonsils
___Nose bleeds

___Fever
___Always hungry

Male Reproductive

___Burning/discharge
___Painful testicles
___Lumps/swelling of testicles
___Vasectomy

Female Reproductive

___Age of first period
___Heavy bleeding
___Vaginal discharge
___Painful intercourse
___Breast pain
___Infertility
___Mood Swings
___Regular
___Clots
___Color/amount
___Cervical dysplasia
___Breast lump
___Genital herpes
___Dry vaginal lining
___Length of cycle
___Pains/cramps
___Vaginal itching
___Pelvic pain
___Anemia
___Hot flashes
___Osteoporosis

Contraceptive/Pregnancy History

___BC Pills
___Diaphragm
___Cervical Cap
____Rhythm
____Condoms
____Spermicides
___IUD
___Mucous method
___Fertility lens

Please list each pregnancy you have had, including miscarriages and abortions:

CURRENT STATE OF EMOTIONS AND SPIRITUAL WELL-BEING

Take time to think about and answer the following questions

Are you completely satisfied with your living conditions?

Are you able to express your feelings and emotions?

Is there an excess of stress in your life? What is causing the stress?

Are you satisfied with your job?

If in a relationship, are you satisfied with it? Are you lonely?

Is there something you would like to change in your life? Can you change it?

Are you a "nervous type" of person? What type of things make you nervous?

Do you sleep well? How many hours (in a 24-hour period)?

Do you dream? Do you remember your dreams?

Are you satisfied with your energy level? Do you often feel exhausted?

Is it easy to wake up in the morning?

Do you enjoy your work?

Do you have hobbies/activities you enjoy outside of work?

Which of these feelings dominate your life?

Joy Happiness Anger Sadness Fear Sympathy Worry Depression Other

Do you believe in a higher power? Are you at peace with this belief/ relationship?

Please list approximate dates and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residence, injury, death of a loved one, car accident etc.

LIFESTYLE HABITS

Routine physical exercise: Type of exercise

For how many minutes How often?

Tobacco use: How much? Previously?

Alcohol use: How much? How often?

Caffeine use: How much How often?

Mood altering substances (such as cocaine, marijuana, etc.):

How much? How often?

How many hours of television do you watch in a week?

Please use this space to add any other information about yourself that you think is relevant.

Thank you for taking the time to fill this out 😊