Lindsay Rose Holistic Health

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Client Health Form & Questionnaire

Last Name: ________________________ **First Name**: ________________________
Address: ________________________ Postal Code: ________________________
Best Phone # to contact you: ________________________ Date of Birth:________________________
How did you hear about me? ________________________ Occupation:________________________
Email: ____

What is your 1st concern you want help with or what do you want changed/shifted in your life?
____
____

When did this start or you first noticed this? ________________________
What life changes or stressors were happening at the time it began?________________________
____
What affects / impacts / sets it back? ________________________
Anything else you want to mention: ________________________

What is your 2nd concern you want help with or what do you want changed/shifted in your life?
____
____

When did this start or you first noticed this? ________________________
What life changes or stressors were happening at the time it began? ________________________
____
What affects / impacts / sets it back? ________________________
Anything else you want to mention: ________________________

Lifestyle Questions

How well do you normally sleep? ❑ Not well ❑ Good ❑ Great How many hours? ___________
What layers feels out of balance or blocked? (circle): Physical Emotional Mental Spiritual Energetic
What is your current stress level? *Low* 1 2 3 4 5 6 7 8 9 10 *High*
What are 3 sources of stress or worry right now?
1. ____
2. ____
3. ____

What were the 3 most significant changes (positive or negative) you experienced as a child or teen?
1. ____
2. ____
3. ____

What are the 3 most significant changes (positive or negative) you've experienced as an adult?
1. ____
2. ____
3. ____

What holistic therapies have you experienced? ❑ Reiki ❑ Energy/Chakra Healing ❑ Access Bars
❑ Shiatsu ❑ Massage ❑ Bowen Therapy ❑ Counselling ❑ Acupuncture ❑ Acupressure
❑ Other (list) ____

Health History

Key: P = Past and C = Current *— Please add your comments to clarify the condition*

General Conditions

❑ Headaches / Migraines
❑ Anxiety / Panic Attacks
❑ Depression – # years____
❑ High Stress - # months___
❑ Mental Illness______
❑ Fatigue / Exhaustion
❑ Lack of Focus
❑ Insomnia
❑ Cancer____________
Treatments____________
❑ Chronic Pain _______
❑ Contagious Illness
❑ Emotionally Unbalanced
❑ Energetically Unbalanced
❑ Post Traumatic Stress
❑ Other________________

Comments:

Muscular / Skeletal

❑ Joint Stiffness / Swelling
❑ Spasms / Cramps
❑ Strains / Sprains
❑ Broken / Fractured Bones
❑ Dislocations
❑ Tendonitis
❑ Bursitis
❑ Arthritis
❑ Scoliosis
❑ Osteoporosis
❑ Bone / Joint Disease
❑ Chest / Rib Pain
❑ Shoulder / Neck Pain
❑ Back Pain
❑ Arm / Hand Pain
❑ Leg / Hip/ Foot Pain
❑ Other________________

Comments:

Neurological /Throat /Skin

❑ Dizziness
❑ Concussions - # _______
❑ Eye / Vision problems
❑ Poor hearing / Ringing Ears
❑ Head Trauma
❑ Skin Sensitivities
❑ Eczema / Psoriasis
❑ Rashes
❑ TMJ/Jaw problems
❑ Grinding teeth
❑ Throat infections
❑ Abnormal Moles
❑ Athlete's Foot / Warts
❑ Cosmetic Surgery: where?_______________
❑ Other________________

Comments:

Cardiovascular

❑ High Blood Pressure
❑ Low Blood Pressure
❑ Pace maker
❑ Diabetes
❑ Chest pain
❑ Irregular heart beat
❑ Bruise / Bleed easily
❑ Blood Clots
❑ Fainting
❑ Dizziness
❑ Sweats/Chills/Fever
❑ Stroke
❑ Lymphedema
❑ Varicose veins
❑ Heart Condition
❑ Other _______________

Comments:

Respiratory

❑ Asthma
❑ Allergies________________
❑ Bronchitis
❑ Lung Cancer
❑ Pneumonia
❑ Sinus Discomfort
❑ Shortness of breath
❑ Chronic cough
❑ Other ________________

Comments:

Digestive and Uro-Genital

❑ Liver / Gall Bladder
❑ Gall stones
❑ Kidney or Kidney Stones
❑ Venereal disease
❑ Indigestion / Reflux
❑ Excess Gas/Bloating
❑ Colitis
❑ Crohn's Disease
❑ Constipation
❑ Diarrhea
❑ Irritable Bowel
❑ Nervous Stomach
❑ Bladder Infection
❑ Abdominal Pain
❑ Adaptive Aids
❑ Other ________________

Comments:

Gynecology / Reproductive

❑ Currently Pregnant? ______
❑ Vaginal Births - # ________
❑ Cesarean Births - #_______
❑ Traumatic Birth Experience
❑ Miscarriages - # ____
❑ Abortions - #______
❑ Fertility Concerns
❑ Fertility Treatments
❑ Menopause - Age __
❑ Breast Lumps/Cysts
❑ Breast Cancer
❑ Endometriosis
❑ Ovarian Cysts / Cancer
❑ Uterine Cysts / Fibroids
❑ Hysterectomy Date ______
❑ Other ________________

Comments:

Spinal & Nervous Systems

❑ Spinal Injury
❑ Sciatica
❑ Herniated Disc
❑ Fibromyalgia
❑ Seizures / Epilepsy
❑ Tremors / Shaking
❑ Parkinson's Disease
❑ Cerebral Palsy
❑ Numbness / Tingling
❑ Twitching / Spasms
❑ Paralysis
❑ Stroke
❑ Muscular Dystrophy
❑ Multiple Sclerosis
❑ Neurological Condition
❑ Other________________

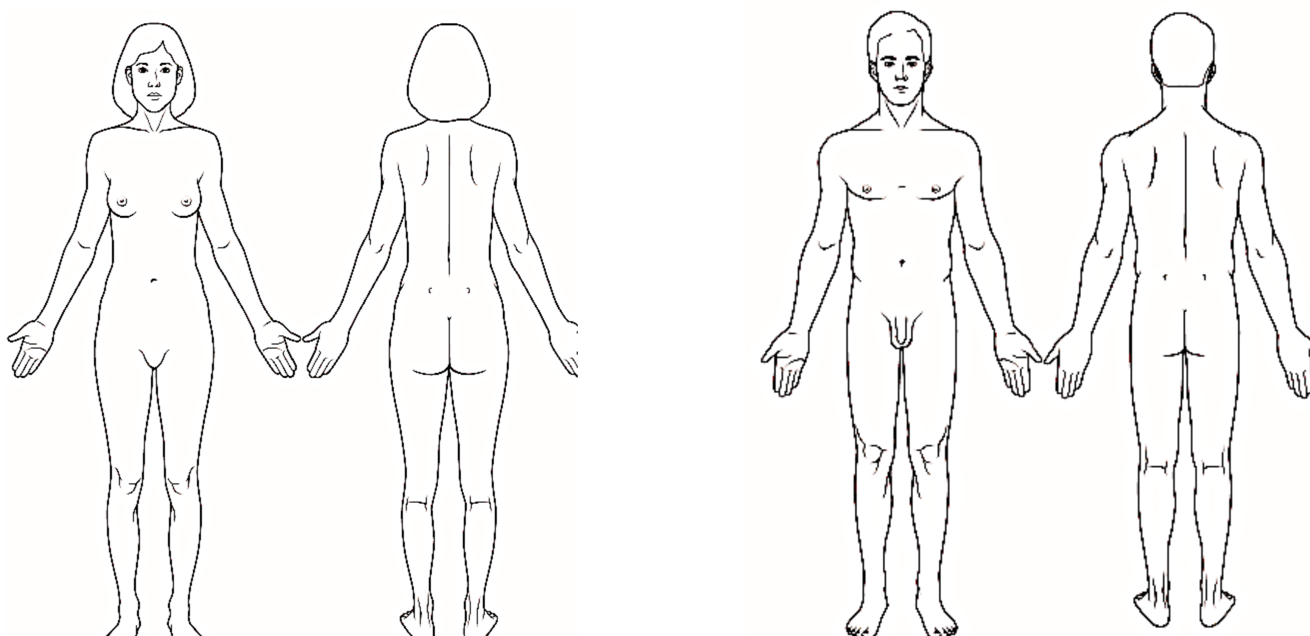
Comments:

List any injuries, accidents or surgery:
1.____
2.____
3.____

Emergency Contact: Name_________________________ Phone ___________________________

In a standard treatment, the full body may be worked on with the exception of breasts and genitals.
Please list any areas of your body you do not want touched or worked on _________________________

Please Indicate Areas of Discomfort:



Client Consent

I have reviewed, understand and agree to the information about Policies and Procedures, Confidentiality and Privacy Policies explaining how Lindsay Rose Holistic Health will use my personal information, and the steps that are taken to protect my information and confidentiality. I agree that Lindsay Rose Holistic Health can use and disclose personal information about me as set out in the Privacy Policies.

By my signature below, I understand that holistic therapy is not a substitute for medical treatment and that it is recommended that I concurrently work with my Naturopath and/or Physician for any condition I may have. I'm aware holistic practitioners do not diagnose illness or disease and do not prescribe medications.

I have informed my Practitioner of all my known physical, emotional, mental and medical conditions, *and will keep Lindsay Rose Holistic Health updated on any changes*.

By my signature below, I consent to treatment. I certify all information provided is accurate. I understand that failure to give full information or any inaccuracies may result in an incorrect treatment approach.

________________________________   ____
Date   Signature