Natural HEALTH and WELLNESS of New England

Client Assessment Form and Health Profile

Today's Date: _____

Name: _____ Age: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____

Home: (___)_____ Cell: (___)_____ Work: (___)_____

Email: _____

Whom may we thank for referring you? _____

Emergency Contact

Name: _____ Relation: _____

Home: _____ Cell: _____ Work: _____

Do you have any allergies? (Please describe)

_____
_____

Current symptoms/health complaints or concerns:

_____
_____
_____
_____

_____
_____
_____

Duration of the above: _____

Have you been treated for the symptom, complaint, or concern mentioned on the pervious page? If yes, please describe.

_____
_____
_____
_____

Are you presently taking any prescription medication? Please list

_____
_____

Do you presently take any herbs, vitamins, or supplements? Please list

_____
_____

Past Medical History

☐ Alzheimer's Disease	☐ Frequent Urination	☐ Osteoporosis
☐ Anemia	☐ Gallbladder Problems	☐ Parkinson's disease
☐ Aneurysm	☐ Gout	☐ Peripheral Vascular Disease
☐ Arteriosclerosis	☐ Headaches	☐ PMS
☐ Asthma	☐ Heart Disease	☐ Pneumonia
☐ Auto Immune Deficiency	☐ Hepatitis	☐ Psoriasis
☐ Bone Disorders	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Bronchitis	☐ High Cholesterol	☐ Sexually Transmitted
☐ Cancer	☐ Irritable bowel Syndrome	Disease

☐ Chronic Fatigue Syndrome	☐ Kidney Disease	☐ Skin Disorders
☐ Cirrhosis	☐ Kidney Stones	☐ Stomach Disorders
☐ Crohn's Disease	☐ Leukemia	☐ Stroke
☐ Diabetes	☐ Liver Disease	☐ Ulcerative Colitis
☐ Difficulty Urinating	☐ Lupus	☐ Ulcers
☐ Eczema	☐ Muscle Disorders	☐ Urinary Tract Infections
☐ Emphysema	☐ Obesity	
☐ Fibromyalgia	☐ Osteoarthritis	
☐ Other _____		

Comments:

Please list any surgery:

_____

_____

Do you smoke? (Yes/No) How much? _____ For how long?_____

Are you a former smoker? (Yes/No)

Do you drink alcohol? (Yes/No) How much? _____ How often: _____

Do you or have you used illegal drugs? (Yes/No) _____

Do you dye your hair? _____ How often: _____

Have you traveled outside the US? _____When? _____ Where? _____

Exercise Habits

Do you exercise? (Yes/No) How often: _____ For how long:_____

What type of exercise? _____

Sleep Habits

How do you sleep?_____How many hours per night do you sleep?_____

Do you wake up at night?_____ Can you fall back asleep? _____

Do you feel rested when you wake up? _____

What do you do for work?_____ How many hours do you work? _____ Do you enjoy your work? _____
How is your relationship with co-workers?_____

Have you been through any serious trauma? When? (This can be anything that seriously affected you: loss of family, friend, pet, divorce, recent move, unemployment, illness, new job, accident, etc.)

_____
_____
_____
_____
_____
_____

Are you happy/unhappy with any relationships with family or friends?

_____
_____

Is your home environment generally happy, peaceful, or is it stressful?

_____
_____
_____

Are you currently under a great deal of stress? Please explain

_____
_____
_____
_____

What helps you relieve stress?

_____
_____
_____

For Females

Is your menstruation regular? _____ If you have difficulty with menstruation please explain:_____

_____
_____

Are there any other problems or concerns that you would like to share?
_____
_____
_____
_____
_____

Rate your current energy level (1-10) 1 – extremely low energy. 10 – Vibrant, full of energy

Now_____ Before current symptoms_____