

Heart Guided Healing Health History

Date: _____

Name: _____ Mobile Phone _____ text? Y/N Home phone: _____

E-mail: _____ Address: _____

How did you hear about Heart Guided Healing? _____

Emergency contact name: _____ Phone: _____

Previous experience with energy work or therapy: _____

What is the major complaint or condition you are seeking help for? _____

When did this begin? _____

What treatment have you had for this condition? _____

What does this condition prevent you from doing? _____

Is this condition: worsening improving unchanged

Have you seen a physician for this problem? Yes No Physician's Name: _____

Are you pregnant? Yes No Due date: _____ Do you have a history of Cancer? Yes / no

Have you ever had the following?:

CROWN

- Migraine
- Head Injury
- Seizures
- Stroke/CVA
- Eye Disorder
- Addictions/
lack of will power

AJNA

- Chronic Sinus Problems
- Head Injury – forehead

ALTA MAJOR

- Jaw problems
- Neuropathy/Numbness
Nerve problems

SOLAR PLEXIS

- Liver Disease
- Stomach Disorders
- Significant trauma –
Emotional/physical/shock

- Spleen, pancreas, stomach
Liver, gallbladder problem
- Digestive Problems
- Colon/Intestinal Disorder

BASIC CENTER

- Kidney Disease
- Chronic Fatigue
- Back Pain
- Neck Pain
- Uncontrolled urine leakage
- Urinary problems – Bladder,
Ureter, Urethra
- High levels of Fear
- Low courage

SACRAL CENTER

- Problems with Uterus/
reproductive/prostate
- tubal ligation or vasectomy
- Hormone imbalance

- Hip/ Knee/Ankle problems
- I don't feel grounded

HEART CENTER

- Heart Attack/MI
- Blood Clot/DVT
- Heart Disease
- Lung Disease
- High Blood Pressure
- Pacemaker
- Low Immune System
- Allergies

THROAT CENTER

- Arthritis
- Thyroid Problem
- Shoulder/Elbow/Hand
problem
- Lymphedema/swelling
- Other Lymphatic Disorders
- I feel like I can't speak up
- I don't listen very well
- Hearing Problems

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OTHER

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gland Problems | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chemo/Radiation therapy |
| <input type="checkbox"/> Fibromyalgia Syndrome | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer/Tumor |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Panic Attacks | |

Other conditions: _____

Please list all medications and nutritional supplements you are taking: _____

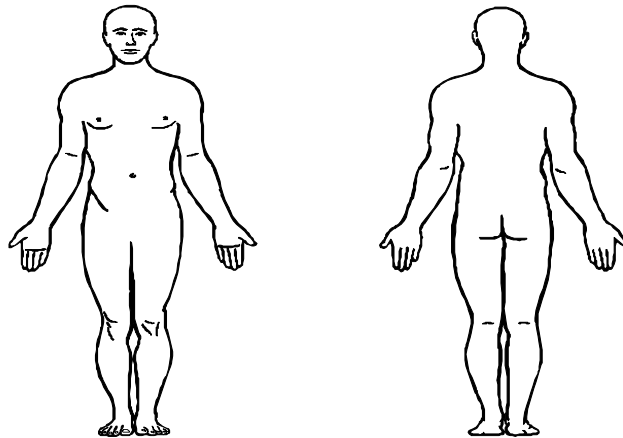
Please list all surgeries:	Type	Date

PAIN: Please color in your conditions and injuries:

What is your pain level on average?

0
2
4
6
8
10

No pain
Worst possible



The information I have provided is accurate and complete to the best of my knowledge. I understand that any care or recommendation I receive in this clinic is not a substitute for a physician's care. I take responsibility for alerting my practitioner of any changes to my health status, medications, and therapies before the session, as well as any and all responses perceived to be a result of Esoteric treatment as soon as I become aware of them. I accept that Esoteric Healing may not cure me or eliminate my health problems. However, Esoteric Healing has shown to be a valuable alternative treatment. The general benefits of Esoteric Healing and any cautions or contraindications have been explained to me. This facility reserves the right to refuse services at their discretion based upon the client's conditions, therapist's skill set, client attitude or action, etc, without explanation or prior notice, and I agree to this policy.

I give consent to Heart Guided Healing for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me, and for general administrative operations. You may contact me for appointment reminders, schedule changes, or other needs and you may add me to your e-mail newsletter directory.

Signature: _____ Date: _____