Circle of Life Healing Arts LLC
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NEW CLIENT HEALTH EVALUATION

Name: _____ Date: _____ Birthdate: _____ Age: ____

Phone: _____Fax: _____ Email: _____

Primary Health Care Provider: _____Phone: _____

Emergency Contact: _____ Phone: _____

Reason for today's visit (Describe concerns, duration, etc.): _____

_____

_____

What is your primary goal for our work together? _____

_____

_____

Current and Past Health History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your health status changed over the past year? ☐ Yes ☐ No

Height: _____ Weight: _____ Has your weight changed over the past year? ☐ Yes ☐ No

Allergies: _____

What kind of reaction do you have? _____

Do you have regular (yearly) physicals? ☐ Yes ☐ No

Please check any medical conditions that you have been diagnosed with:

☐ Heart conditions or surgery
☐ High blood pressure
☐ Stroke
☐ High cholesterol
☐ Hepatitis/liver disease
☐ Osteopenia
☐ Osteoporosis
☐ Cancer (type) _____

☐ Diabetes
☐ Headaches
☐ Migraine headaches
☐ Blood clot/thrombophlebitis
☐ Thyroid
☐ Gall bladder problems
☐ Bladder/kidney problems
☐ Sexually transmitted disease (type) _____

☐ ADD/ADHD
☐ Bipolar disorder
☐ Depression
☐ Schizophrenia/psychosis
☐ Anxiety or panic disorder
☐ Post traumatic stress disorder
☐ Personality disorder
☐ Other mental health: _____ _____

Other: _____

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Please list any surgeries you have had and the year: _____

_____

Have you had your cholesterol checked in the past two years? ☐ Yes ☐ No

If so, were the results normal? ☐ Yes ☐ No

Have you had a fasting blood sugar test done in the past two years? ☐ Yes ☐ No

If so, were the results normal? ☐ Yes ☐ No

Have you had blood work to test your thyroid level? ☐ Yes ☐ No

If so, were the results normal? ☐ Yes ☐ No

Please provide us with copies of the above laboratory reports, if possible.

Family History	**(Relationship)**
Cancer (type) _____	_____
Heart disease (before age 55)	_____
Stroke	_____
Diabetes	_____
Osteoporosis	_____
High Blood Pressure	_____
High cholesterol	_____
Alzheimer's	_____
Mental Illness	_____
Obesity	_____
Thyroid	_____
Other _____	_____

Over-the-Counter, Vitamins/Herbals/Supplements ***(Please bring them with you)***

Name	**Dose**	**Frequency**	**Why do you take this?**

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Prescriptions/Medications ***(Please bring them with you)***

Name	Dose	Frequency	Why do you take this?

Social History

Status: ☐ Married ☐ Single ☐ Coupled ☐ Divorced ☐ Widowed

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Are you currently sexually active? ☐ Yes ☐ No Number of sexual partners (lifetime) _____

Have you ever been hit, slapped, kicked or otherwise hurt by someone? ☐ Yes ☐ No

If yes, within the past 12 months? ☐ Yes ☐ No

Have you ever been forced to have sexual activity with someone that you did not want to have? ☐ Yes ☐ No

Do you wear your seat belt when you drive? ☐ Yes ☐ No

What is your educational background? _____

What is your occupation? _____

Do you enjoy your job? ☐ Yes ☐ No Do you work different shifts? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Did you smoke at one time? ☐ Yes ☐ No

If yes, packs per day? _____ For how many years? _____ What was your quit day? _____

How many alcoholic drinks do you have per week? _____ per month? _____ per year? _____

How many caffeinated drinks do you have per day? _____

Do you use recreational drugs? ☐ Yes ☐ No

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How many hours do you usually sleep each night? _____

Are you a restless sleeper? ☐ Yes ☐ No Do you feel rested upon rising? ☐ Yes ☐ No

Do you have difficulty falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Have you been told you snore? ☐ Yes ☐ No

Have you been told you pause in your breathing while asleep? ☐ Yes ☐ No

Are you currently involved in regular exercise? ☐ Yes ☐ No

How many hours a week do you:

Perform vigorous exercise (brisk walking, jogging, biking, aerobics) _____

Perform strength training (weight machines or free weights) _____

Perform stretching exercises (yoga, tai chi, ballet, general stretching) _____

How long have you been doing your current exercise routine? _____

Do you feel you eat a healthy diet most days? ☐ Yes ☐ No

How many meals do you usually eat per day? _____ Snacks? _____

How many meals do you usually eat away from home each day? _____

Number of fruits _____ vegetables _____ per day?

Servings of calcium per day? _____

What is your appetite like? _____

Have you unintentionally gained or lost >10# in the past 3 months? ☐ Yes ☐ No

Do you find yourself fluctuating between weight loss and weight gain? ☐ Yes ☐ No

	Never	Hardly Ever	Sometimes	Nearly Always	Always
Do you feel in control of your eating habits?	☐	☐	☐	☐	☐
Do you feel in control of your lifestyle?	☐	☐	☐	☐	☐
Do you find yourself obsessing about food, weight, and/or body image?	☐	☐	☐	☐	☐

What do you do for fun? _____

Is it still fun? ☐ Yes ☐ No

Over the past 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No

Over the past 2 weeks, have you lost interest or pleasure in doing things that normally give you pleasure? ☐ Yes ☐ No

What do you do for relaxation? _____

Do you have a spiritual/religious practice? ☐ Yes ☐ No If so, please describe: _____

_____

Have you experienced any of the following events in the past year?

☐ Death of a spouse
☐ Divorce
☐ Marital separation
☐ Jail term
☐ Death of a close family member
☐ Personal injury or illness
☐ Marriage
☐ Loss of a job
☐ Marital reconciliation
☐ Retirement

☐ Other _____

Men Only:

BPH (Prostate enlargement)? ☐ Yes ☐ No

Trouble starting/stopping your stream of urine? ☐ Yes ☐ No

Trouble with incontinence or leaking urine? ☐ Yes ☐ No

Do you need to urinate in the night? ☐ Yes ☐ No Times? _____

Have you had a prostate test (PSA) done? ☐ Yes ☐ No

What were the results? _____

Do you have difficulty with an erection or maintaining an erection? ☐ Yes ☐ No

Do you experience any other sexual difficulties? ☐ Yes ☐ No

If yes, please explain: _____

_____

Men: Go to page 7

Women Only:

History of:

Fibrocystic disease? ☐ Yes ☐ No

Uterine fibroids? ☐ Yes ☐ No

Abnormal vaginal bleeding? ☐ Yes ☐ No

Polycystic ovary disease? ☐ Yes ☐ No

Form of birth control? _____

Any problems with birth control? _____

On a scale of 0 to 10, with 10 representing very severe symptoms, how would you describe the following (please circle)?

Pain or symptoms during your usual period 0 1 2 3 4 5 6 7 8 9 10

PMS (premenstrual syndrome) 0 1 2 3 4 5 6 7 8 9 10

Describe your PMS symptoms (or history of menopausal, if applicable): _____

_____

Surgeries:

☐ Removed uterus Reason: _____

☐ Removed one ovary Reason: _____

☐ Removed two ovaries Reason: _____

☐ Single or double mastectomy Reason: _____

☐ Cervical conization Reason: _____

☐ Other _____

Obstetrical History: # of pregnancies _____ # of births _____

Any problems with fertility? ☐ Yes ☐ No

Last bone density test (DXA) Date: _____

Results: ☐ Normal ☐ Osteopenia ☐ Osteoporosis

Last Mammogram : Date _____ Result _____

Last Pap Smear : Date _____ Result _____

Periods: When was your last period? _____

Describe your periods (heavy, painful, etc.) _____

☐ None

☐ Regular

☐ Irregular

☐ Bleeding between periods

☐ Recently changing

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Men and Women:

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty concentrating					
Fatigue/loss of energy					
Can't sleep (insomnia)					
Depressed or unhappy					
Anxious					
Headaches					
Moodiness/emotional swings					
Painful or swollen breasts					
Craving for sweets and/or carbohydrates					
Loss of sex drive					
Weight gain/bloating					
Night sweats					
Memory problems					
Hot flashes					
Vaginal dryness (women only)					
Dry hair/skin					
Incontinence or leaking urine					
Urinary tract infections					
Inability to reach orgasm					
Painful intercourse (women only)					
Itching skin					
Constipation					
Hair loss/thinning					
Other (please describe):					

Additional comments: _____

_____

_____

_____

_____

_____ _____

Signature Date