JOURNEYS to the SACRED WITH CARA ANDERSHOCK

Health History Form

Name: _____
LAST FIRST M.I.

Address:
_____
CITY ZIP CODE

Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Marital Status: (circle one) Single / Married / Separated / Divorced / Committed Relationship

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Referred by: _____

Current Medications / Supplements: _____

_____

_____

_____

Physician (name/phone): _____

Therapist (name/phone): _____

Are you currently pregnant? _____ Or trying to become pregnant? _____

Are you ok with the use of essential oils? _____

Amount Daily intake: Water _____ Caffeine _____

Alcohol _____ Cigarettes / Tobacco _____

Do you currently use recreational drugs? (circle one) Yes / No

If so, what and how frequently: _____

_____

Children: (circle one) Yes / No Ages of Children: _____

Pets: (circle one) Yes / No What kind(s): _____

_____

Are you currently employed? (circle one) Yes / No

Line of work / Job Title: _____

Reason for visit or presenting complaint:

_____

_____

_____

_____

_____

_____

EMOTIONAL/PSYCH	PAST	CURRENT
Depression		
Anxiety		
Phobias		
Mood Swings		
Panic Attacks		
Obsessive Compulsive Disorder		
Bipolar		
Suicidal Thoughts		
Suicidal Attempts		
Insomnia		
Eating Disorder		
Substance Abuse (type)		
Stress		
ADD/ADHD		
Grief		
Personality Disorder (type)		
PTSD		
Other:		

NEUROLOGICAL SYSTEM	PAST	CURRENT
Recurrent Headaches		
Migraines		
Epilepsy		
Seizures		
Parkinson's Disease		
Shingles		
Dizziness		
Concussion		
Twitches/Ticks		
Multiple Sclerosis		
Bell's Palsy		
Chronic Fatigue Syndrome		
Chronic Pain		
Dementia		
Lupus		
Meningitis		
Head/Neck Injury		
Other:		

ENT	PAST	CURRENT
Sinus Problem		
Eye Problem		
Ear Problem		
Throat Problem		
Jaw Pain		
Gum Disease		
Other:		

URINARY SYSTEM	PAST	CURRENT
Bladder Infection		
Kidney Infection		
Kidney Stones		
Blood in Urine		
Bladder Control		
Other:		
Other:		

CARDIOVASCULAR SYSTEM	PAST	CURRENT
Heart Murmur		
Heart Palpitations		
Angina		
Heart Attack		
Heart Failure		
Blood Pressure		
Low Blood Pressure		
Stroke		
Aneurism		
Anemia		
Disorders: Hemophilia/Other		
High Cholesterol		
Other:		
Other:		

MUSCULOSKELETAL SYSTEM	PAST	CURRENT
Bone Injuries		
Joint Injuries		
Muscle injury		
Arthritis		
Bursitis High		
Tendonitis		
Carpal Tunnel		
Back Pain		
Bulging/Herniated Disc		
Gout Bleeding		
Fibromyalgia		
Muscle Cramps		
Osteoporosis		
Other:		

RESPIRATORY SYSTEM	PAST	CURRENT
Seasonal Allergies/Hay Fever		
Asthma		
COPD		
Pneumonia		
Bronchitis		
Tuberculosis		
Emphysema		
Smoker		
Shortness of Breath		
Sleep Apnea		
Bronchial Disorder		
Interstitial Lung Disease		
Pulmonary embolism		
Cystic fibrosis:		
Other:		

AUTO-IMMUNE SYSTEM	PAST	CURRENT
AIDS / HIV		
Allergies		
Cancer (type)		
Tumor		
Chronic fever		
Fatigue		
Fungal Infections		
Herpes (type)		
Lyme Disease		
Mononucleosis		
Skin Disorder (type)		
Shingles		
Cysts:		
Other:		
Other:		

GASTROINTESTINAL SYSTEM	PAST	CURRENT
Stomach Aches		
Constipation (chronic)		
Diarrhea (chronic)		
IBS		
Indigestion		
Small Intestine Disorder		
Intestinal Obstruction		
Diverticulitis		
Stomach Disorder		
Reflux Disease		
GERD		
Ulcers		
Gastritis		
Liver Disorder		
Hepatitis		
Jaundice		
Gall Bladder Problems		
Crohns Disease		
Colitis		
Appendicitis		
Other:		

ENDOCRINE/METABOLIC SYSTEM	PAST	CURRENT
Pre-Diabetic		
Gestational Diabetes		
Type 1 Diabetes		
Type 2 Diabetes		
Thyroid Disorder		
Pituitary Disorder		
Thalamus Disorder		
Hyperthyroid		
Hypothyroid		
Adrenal Fatigue		
Addison's Disease		
Cushing's Disease		
Graves Disease		
Growth Hormone Deficiency		
Per-Menopausal		
Post-Menopausal		
Low Testosterone		
Obesity		
Hypoglycemia		
Other:		
Other:		

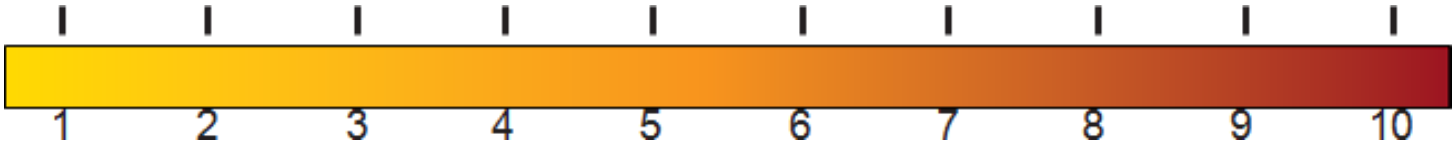
REPRODUCTIVE SYSTEM	PAST	CURRENT
Sexually Transmitted Disease		
Endometriosis		
Fertility Issues		
Pregnancies (number)		

OTHER	PAST	CURRENT
Victim of Sexual Assault		
Victim of Physical Assault		
Witnessed Traumatic Event		
Served in Military Combat		

REPRODUCTIVE SYSTEM	PAST	CURRENT	OTHER	PAST	CURRENT
Miscarriage (number)			Emotional Abuse		
Abortions (number)			Physical Abuse		
Hysterectomy			Sexual Abuse		
Vasectomy			Intense Teasing/Bullying		
Cesarean Childbirth:			Other:		
Other:			Other:		

Additional Questions

1. What is your current stress level? On a scale of 1–10, how stressful is your life? Please mark your answer on the scale.



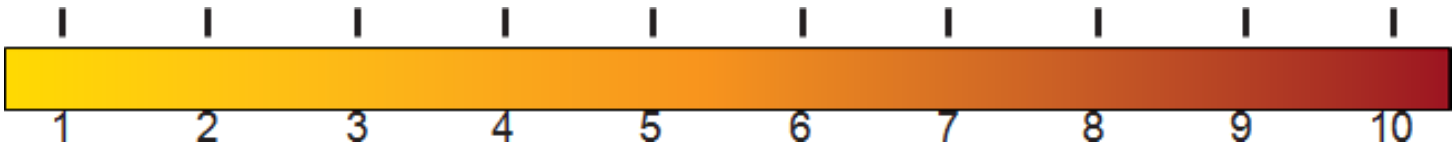
Content & Peaceful ← → Not sure how I'm surviving

2. Please list any injuries and broken bones you have had or have:

3. Please list any surgeries you have had or know you will have:

4. Please list any traumatic or life-threatening events that occurred in your life and when they happened:

5. On a scale of 1–10, how happy/loving was your childhood? Please mark your answer on the scale.



Not sure how I survived it ← → Happy & Loving

6. How many children in your immediate family? Where were you in birth order?

7. Describe your relationship with your birth mother and if applicable your step mother.

8. Describe your relationship with your birth father and if applicable your step father.

9. Describe your relationship with your siblings.

10. Describe your relationship with your spouse, partner, significant other.

11. Describe your relationship with each of your children.

12. What do you hope for, and what are your expectations from this healing both today and long-term?

13. What alternative health therapies have you experienced (e.g., Reiki, Acupuncture, Healing Touch, massage, etc.)?

14. Do you consider yourself a spiritual person? (circle one) Yes / No Care to elaborate?

15. What was your family of origin Faith or practices?

16. What spiritual practices do you engage in (e.g., meditation, prayer, church, yoga, Tai Chi, etc)?