Holistic Health Practice
New Patient Questionnaire

Date_____

Please check with whom your appointment is scheduled :

Practitioner: ☐ Kurt Hill

☐ _____

☐ _____

Contact Information

Name _____ Home Ph# _____

Address_____ Work Ph# _____ Ext ____

_____ ☐ Please add my name to your mailing list.

Referred by _____ ☐ Please do not add my name to your mailing list.

Sex: M F Birthdate _____ Email _____

Single Married Widowed Separated Divorced

In Case of Emergency, Contact Name _____

Occupation _____

Relationship _____

Employer _____

Home Ph # _____

Employer Ph# _____

Work Ph # _____

What is the reason for your visit?

_____

_____

_____

_____

Medical History

Date of last physical examination _____

Your principal health care provider _____

Phone number _____

Medical History

Check symptoms you currently have or have had in the past year.

General

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Weight Gain
- ☐ Numbness
- ☐ Sweats

Eye/Ear/Nose Throat/Gums

- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Vision – Flashes/Halos
- ☐ Ringing in ears
- ☐ Ear Ache/Ear discharge
- ☐ Loss of hearing
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Bleeding gums

Gastrointernal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in Moles
- ☐ Scars
- ☐ Sore that won't heal

Cardiovascular

- ☐ Chest pain
- ☐ High/low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Women Only

- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other _____

Date of your last period _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

Men Only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other _____

Number of children _____

Check conditions you have or have had in the past:

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Medications/Allergies

List medications or supplements you are currently taking: _____

_____

_____

List allergies to medications or substances: _____

_____

Energy levels and general life attitude

- ☐ Good appetite
- ☐ Low appetite
- ☐ Always hungry
- ☐ Difficulty sleeping
- ☐ Depression
- ☐ Mental sluggishness
- ☐ Easily tired
- ☐ Positive life attitude
- ☐ Negative life attitude
- ☐ Feel overwhelmed
- ☐ Enjoy physical activity
- ☐ Wake up feeling tired
- ☐ Wake up ready for the day

Substance Use

Check which substances you use and describe how much and how frequent

- ☐ Caffeine _____
- ☐ Recreational drugs _____
- ☐ Tobacco _____
- ☐ Alcohol _____

Occupational Hazards

Check if your work or lifestyle exposes you to the following:

- ☐ Stress
- ☐ Heavy lifting
- ☐ Hazardous substances
- ☐ Sitting or standing for long periods at desk or pc terminal
- ☐ Carpal tunnel syndrome
- ☐ Other _____
- ☐ Other _____

Exercise

Type of exercise you do. Please indicate how often and how long:

- ☐ Walking outdoors _____
- ☐ Treadmill _____
- ☐ Running _____
- ☐ Bicycle _____
- ☐ Aerobic classes _____
- ☐ Weight training _____
- ☐ T'ai Chi _____
- ☐ Yoga _____
- ☐ Swimming _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Family History

Mother Alive Deceased Present health or cause of death _____

Father Alive Deceased Present health or cause of death _____

Sisters Number ____ Alive Deceased Present health or cause of death _____

Brothers Number ____ Alive Deceased Present health or cause of death _____

Family Illnesses

Check illnesses which have occurred in any of your blood relatives:

- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Stroke
- ☐ Nervous Illness
- ☐ Cancer
- ☐ Diabetes
- ☐ Allergy
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Epilepsy
- ☐ Asthma
- ☐ Liver Disease
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Signature

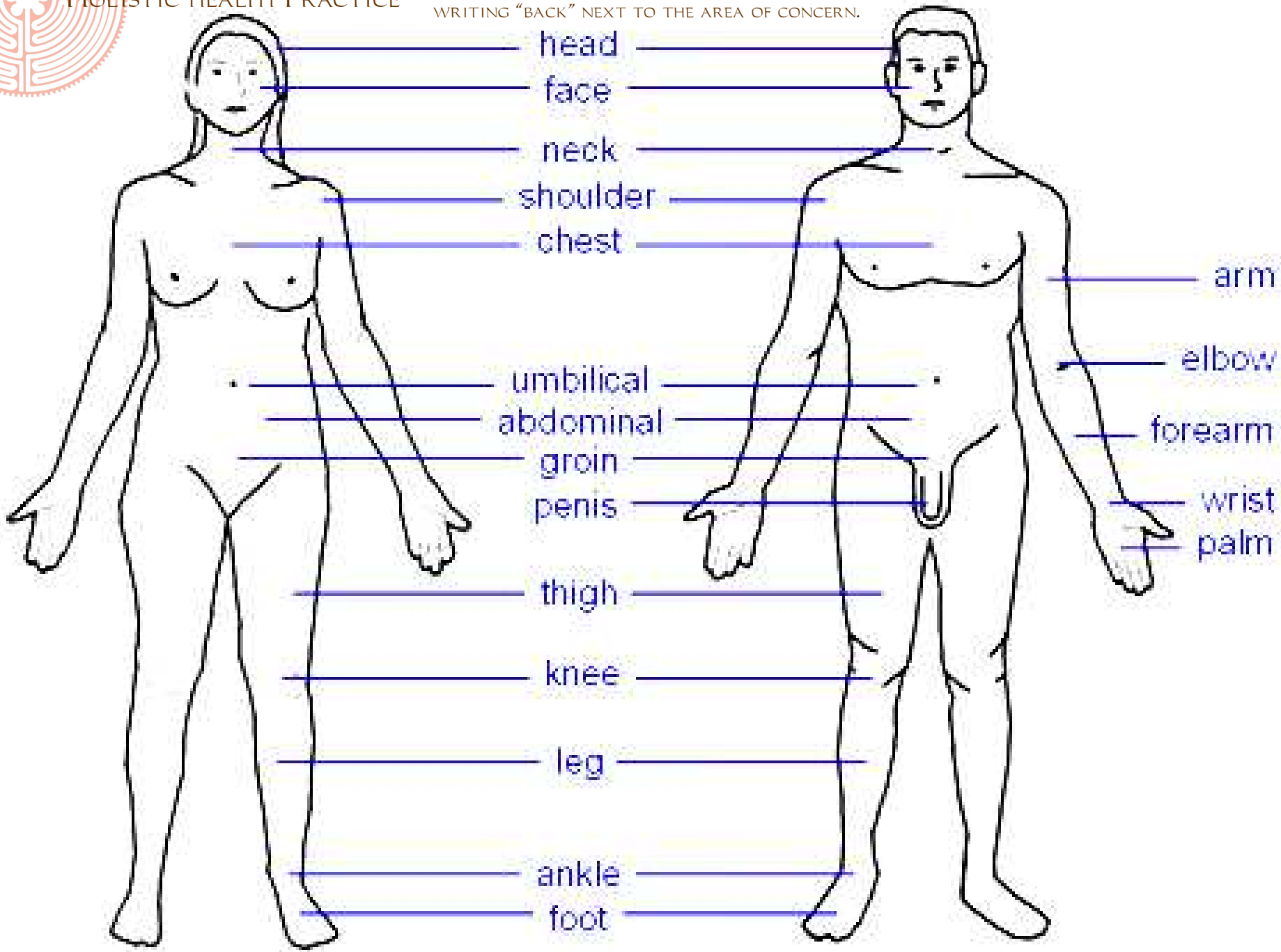
I certify the above information is correct to the best of my knowledge. I will not hold Holistic Health Practice or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____

Holistic health Practice

Please highlight or circle the areas which bring discomfort . If the area in question is On the back side (as opposed this frontal illustration) please make a notation by writing "back" next to the area of concern.



Holistic Health Practice

Consent Form

Name_____

Date_____

Client Consent to Treatment

◊ I, _____ certify that I am a competent adult of at least 18 years of age or that if I am a minor under the age of 18, I understand that the consent of my parent/ legal guardian/person having legal custody will also be required before treatment. This Informed Consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assignees.

◊ I certify that I am in adequate physical, emotional and mental health to participate in treatments at Holistic Health Practice (If not, please specify on the opposite side). I acknowledge that should this information change, it is my sole responsibility to notify the therapists/practitioners/doctors at HHP.

◊ I, _____, consent to and authorize the Holistic Health Practice staff to perform holistic treatment upon me as specified and recommended by my healer. This treatment may include energy and vibrational healing, musculoskeletal massage and manipulation, chiropractic adjustment and acupuncture.

◊ The nature of the service/session has been explained to me and/or is available to me in writing and any questions I had regarding the treatment(s) have been answered to my satisfaction.

◊ I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks. Possible side effects may include dizziness, disorientation, emotional breakthroughs, physical, mental and/or emotional vulnerability.

◊ Alternative means of treatment and their risks have been explained to me, and I understand that I have the right to refuse the treatment.

◊ No guarantee, warranty or assurance has been made to me as to the results that may be obtained.

◊ If applicable, I understand that Kurt Hill is not a physician and does not dispense medical advice or prescribe the use of any technique as a form of treatment for physical or medical problems without the advice of a physician-either directly or indirectly. His intent is only to offer information of a general nature to help his clients in their quest for emotional, mental, physical, and spiritual well-being and assumes no responsibility for how this information is used.

◊ I agree to adhere to all safety precautions and regulations during my treatments/sessions at Holistic Health Practice.

Client Signature _____

Date _____/_____/_____

Please print and return to Holistic Health Practice prior to your initial appointment. Thank you.