My Vital Force Health Information Sheet

Name____ Day Phone______________________________

Address______________________________________ Night Phone____________________________

City____ Cell Phone______________________________

State/Zip______________________-_______________ Email__________________________________

Birth date____________ Age ________ Marital Status _________ Children __________________

Profession ___________________________________ How many years? ______________________

Do You Enjoy Your job/work? Y / N …if No, Why?____

What brings you in today? ____

When was the onset of symptoms? ____________________ Specific events at onset?__________

Your Main Health Goals & Expectations? ____

How many hours of sleep do you get each night? _____________How many hours needed?___

Do you feel like you get quality and quantity of sleep needed?_____________________________

How much exercise/sweaty activities weekly?____________ What type?______________________

How many hours do you sit per day (work or school)? ______________________________________

How many **ounces** of water daily? ___________ What type? Filtered-Distilled-RO-Tap-Spring

How many bowel movements daily?______ Circle- tendency toward constipation or diarrhea

How many meals daily eaten? ________ Circle - if Breakfast Lunch Dinner

Do you follow a specific diet? ____

Have you cut certain things from your diet? ____

How much of the following do you consume? (example, 1D=once daily, 1W= weekly, 3M=3 monthly)

Soda pop________ Alcoholic Bev______ Smoking__________ Coffee/Caffeine___________

Fast Food_______ Fried Foods_______ White Flour_______ Sugar usage_____________

Milk_____________ Dairy_____________ Sugary Foods______Processed Foods__________

Fruits___________ Veggies__________ Eggs_____________ Grains__________________

Meat____________ Fish____________ Beans_____________ Organic Foods____________

What types of food do you crave? Salty Chocolate Sweets Breads Other________________

What are your favorite foods?____

How much daily energy (1 =lowest energy level; 10 =highest energy level) do you have?_____

How many hours of TV do you watch? Daily____________________Weekly___________________

How many hours a week do you spend with family / friends? ______________________________

Rest / Relaxation / Recreation do you get a week? (in minutes / hours)? _________________

Sunlight / Fresh Air / Time in Nature (in minutes / hours)? ______________________________

Do you do breathing exercises daily, weekly, at all? ____

Current Height _____________ Weight ___________ Recent changes? ________________________

Are you pregnant or nursing a baby? ________ Are you trying to get pregnant soon?________

Are you currently on birth control? ___________ Which kind?___________ How long?_________

Any info I should know about your monthly cycle? ____

Allergies? Circle NONE if applicable____

____

Current medications? (Prescription & over the counter) Circle NONE if applicable.

____

____

What major illnesses, injuries, accidents, or surgeries have you had and when? Circle NONE if applicable

____

____

What have you been diagnosed with? ____

Current/Recent Physicians?____

____

What conditions have you been treated for by a physician? ____________________________________

____

What have you tried that did or did not work for you? _______________________________________

____

Have you traveled outside of the USA? Y / N

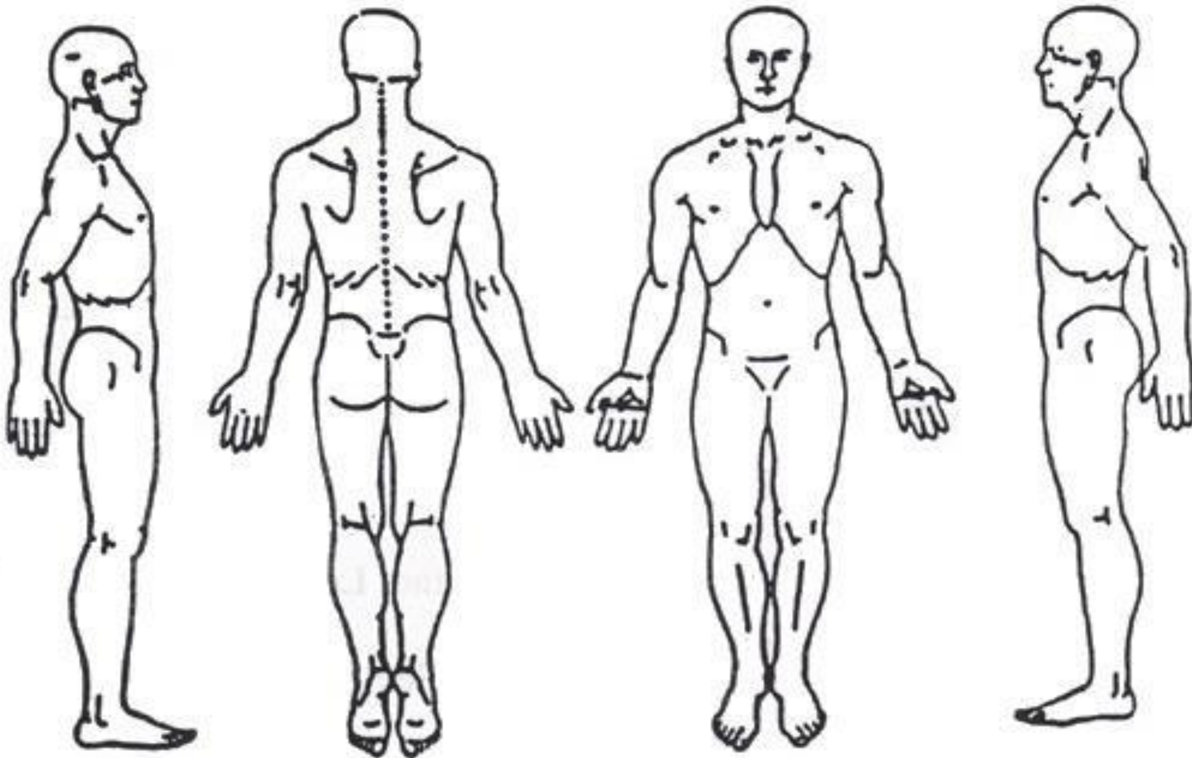
If so when____

Did any of these trips require any vaccinations to travel? If so which ones? ________________

Please indicate below where you are experiencing concerns.

Place an "X" on the line below to indicate the level of the problem.

(No Symptoms) 1————————————————————————————10 (Extreme Symptoms)



Check the following conditions that apply to you, PAST & PRESENT. Add comments for clarification as needed.

Musculoskeletal
- □ Headaches
- □ Joint Stiffness/Swelling
- □ Spasms/Cramps
- □ Strains/Sprains
- □ Neck Pain
- □ Upper/Mid Back Pain
- □ Low Back Pain
- □ Shoulder, Neck, Arm, Hand Pain
- □ Hip, Leg, Foot Pain
- □ Chest/Rib Pain
- □ Numbness/Weakness
- □ Problems Walking
- □ Jaw Pain/TMJD
- □ Tendonitis
- □ Bursitis
- □ Arthritis
- □ Osteoporosis
- □ Scoliosis
- □ Bone or Joint Disease
- □ Other____________________________

Circulatory/Respiratory
- □ Dizziness
- □ Shortness of Breath
- □ Fainting
- □ Cold Hands/Feet
- □ Cold Sweats
- □ Chills
- □ Swollen Ankles
- □ Difficulty Lying Flat
- □ Pressure Sores
- □ Varicose Veins
- □ Blood Clots
- □ Heart Conditions/Chest Pain
- □ Palpitations
- □ Allergies
- □ Sinus Problems
- □ Asthma
- □ Cough
- □ Coughing Blood
- □ Wheezing
- □ Excessive Bleeding
- □ Pace Maker
- □ Lymphedema
- □ Other___________________________

Skin
- □ Rashes
- □ Itching/Burning
- □ Hives
- □ Eczema
- □ Athlete's Foot
- □ Warts
- □ Moles
- □ Acne
- □ Cosmetic Surgery
- □ Other____________________________

Gastrointestinal
- □ Gum Bleeding
- □ Nervous Stomach
- □ Indigestion
- □ Heartburn/Reflux
- □ Nausea/Vomiting
- □ Change in Bowel Patterns/IBS
- □ Constipation
- □ Diarrhea
- □ Jaundice
- □ Abdominal Pain
- □ Gall Bladder Problems/Removal
- □ Diverticulitis
- □ Crohn's Disease
- □ Colitis
- □ Other____________________________

Nervous/Eyes/ENT
- □ Numbness/Tingling
- □ Loss of Strength/Weakness
- □ Paralysis
- □ Twitching
- □ Chronic Pain
- □ Sleep Disorders
- □ Ulcers
- □ Herpes/Shingles
- □ Cerebral Palsy
- □ Epilepsy/Seizures
- □ Chronic Fatigue Syndrome
- □ Multiple Sclerosis
- □ Muscular Dystrophy
- □ Parkinson's Disease
- □ Difficulty Hearing
- □ Ringing in the Ears
- □ Eye Correction
- □ Double Vision
- □ Cataracts
- □ Other___________________________

Reproductive/Urinary
- □ Burning on Urination
- □ Nighttime Urination
- □ Blood in Urine
- □ Erectile Dysfunction
- □ Prostate Problems
- □ Abnormal Discharge
- □ Yeast Infection
- □ Bladder Leakage
- □ Pregnancy
- □ Current □ Previous
- □ PMS
- □ Menopause
- □ Pelvic Inflammatory Disease
- □ Endometriosis
- □ Hysterectomy
- □ Fertility Concerns
- □ Other__________________________

Other
- □ Loss of Appetite
- □ Forgetfulness/Memory Loss
- □ Confusion
- □ Depression
- □ Anxiety
- □ Weight Loss/Weight Gain
- □ Fatigue
- □ Fever
- □ Loss of Hair
- □ Hot/Cold Intolerance
- □ Difficulty Concentrating
- □ Hearing Impaired
- □ Visually Impaired
- □ Eating Disorder
- □ Diabetes
- □ Fibromyalgia
- □ Post/Polio Syndrome
- □ Cancer
- □ Rheumatoid Arthritis
- □ Infectious Disease__________________________
- □ Congenital/Acquired Disabilities

____

____

History of Abuse / Treatment:

Check all that apply

- □ H/O Alcohol Addiction/Treatment
- □ H/O Drug or Elicit/Recreational Drug Abuse
- □ H/O Drug or Elicit/Recreational Drug Treatment
- □ Are you currently on ADD/ADHD Meds

Family History:

Are you adopted? ____ If yes, can you fill out following concerning your natural parents? If not, N/A

Is your father alive? If yes, how old_____ If no, what was the cause of death and age at death?______

Is your mother alive? If yes, how old____ If no, what was the cause of death and age at death?______

Write “F” for father, “M” for Mother, “S” for sibling:

_____Heart Disease _____Lung Disease ______Liver Disease _____Kidney Disease _____Cancer

_____Stroke _____Diabetes _____Asthma _____Arthritis _____ Headaches _____Chronic Pain

_____Mental Illness _____Trouble Sleeping _____Other:____________________________________

Childhood History:

Condition of your Mother’s health while pregnant with you? _______________________________________

Were you born: C-Section / Naturally Breastfed? Y /N If yes, how long? ______________________

Were you fully immunized as a child? Y / N Were you sick often as a child? Y / N

Were you a colicky baby? Y /N Were you constipated as a child? Y / N

How many rounds of antibiotics would you say you had as a child? _______________________________

Circle any of the following & list how many times:

Colds _____ Strep Throat _____ Bronchitis _____ Ear Infections _____ Ear Tubes _____ Rashes _____

Circle any of the following that you’ve ever had, fill in any not listed: ______________________________

Asthma Chicken Pox Shingles Measles Mumps Scarlet Fever Seizures Whooping Coughing

Current Supplements:

Do you take supplements daily 1x / 2x day / 3x day, or most days / or just occasionally?

Food/Digestive Enzymes with each meal?________________________ Daily?__________________________

Vitamins____

Minerals ____

Probiotics ____

Omegas, Essential Fatty Acids, Fish Oils ____

Fiber ____

Antioxidants ____

List other vitamins, herbs, or homeopathics you use ____

____

____

____

Stress:

Please list any current/recent physical or emotional stressors / causes of anxiety in your life: _____

____

How do you cope with stress? ____

____

Please list any significant stresses/traumas (physical or emotional), including the approximate date:

____

____

Which emotions are the hardest for you to deal with (with yourself and/or with others)?__________

____

Do you have a daily practice of self-care? (Journaling, meditation, prayer, deep breathing, stretching)? Please describe ____

How many hours of spiritual enrichment each week? (Bible, prayer, church, etc.) ________________

On a scale of 1-10 how ready/willing are you to make lifestyle changes to improve your health?_____

What things have you already changed? ____

____

Are there certain things you are not willing to change? ______________________________________

Would you like to receive our occasional natural health newsletter? Yes No

How did you find out about us? ____

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements, herbs, oils and therapies as a guide to general good health and this is a personal ministry counseling. The sessions will be *consulting to educate and empower clients* to take an active participation for their own health. The goal is to gain a greater knowledge in relation to your health choices.
I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit an agent for federal, state or local agencies or on a mission of entrapment or investigation.
The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health and do not involve the diagnosing, treatment, or prescribing of remedies for disease. It will be your responsibility to speak with your physician to ensure participation and for medications.
I understand My Vital Force, Kari Solomon, "Association" is part of a private membership of education and information sharing. The Pastoral Medical Association is known as "PMA" and explained on the additional PMA privacy page and website.

Signature_______________________________________ **Date** __________________________

***** Please write on another sheet if there are others things that would be helpful for me to know about you and your health. Thank you!**