



Name					Date
Birthdate / /	Age	Height	Weight	Gender M / F	
Address				Phone	
Status (check all that apply): <input type="checkbox"/> Child <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced					

How did you hear about us? _____
 Employer name and address: _____
 What is your occupation? _____

Your Health Profile; Why These Forms Are Important

As a naturopathic wellness approach, our goals are to first address the issues that brought you to this office and to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical, psychological and emotional stresses that can accumulate and result in serious loss of health potential. Generally the effects are gradual and may not even be felt until they become serious.

Answering the following questions will give us a profile of the specific stresses, past and present, that you face and allow us to better assess the challenges to your health potential.

HIPPA Acknowledgement of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Sano Consulting's Notice of Privacy Practices. Sano is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at any time.

Name:	Signature/Guardian:	Date:
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Goals For My Care: People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, others to correct core malfunctions. Your practitioner will weigh your needs and desires when recommending your program of care.

- Relief care** (symptomatic relief of pain/discomfort)
- Corrective Care** (correcting/relieving cause of problem/symptoms)
- Comprehensive Care** (address entire system bringing body to highest state of health possible)
- Other Goals:** Weight Loss Increased energy Hormone balance Other _____

List Health Concerns According to Severity: Rate 1-Mild to 10-Worst Imaginable

Health Concern	Severity	When did the episode start?	Have you had this before? When?	Begin with injury/trauma/event?	Constant or Intermittent?

Other professionals seen for above condition(s): MD ND Chiropractor Homeopath Other _____

Diagnosis made _____ Treatment received: _____

List all prescription drugs, over-the-counter-drugs and supplements you are currently taking:

Drug/Supplement Name	Date Began	Purpose	Dosage/Quantity

BIRTH TO 17 YEARS	YES	NO	UNSURE
Complications at birth and/or adopted? Describe:			
Serious childhood illness or falls? Describe:			
Did you play youth sports? List:			
Prolonged use of medicine (e.g., antibiotics, inhaler, etc)? List:			
Vaccinated? List:			
Vaccination reactions? List:			
Were you under chiropractic care?			
Comments:			

18 YEARS TO PRESENT	YES	NO	N/A
Contraception/IUD? Describe:			
Pregnant? Due date:			
Sensitivity or allergy to fragrances or oils?			
Do / did you consume alcohol or drugs more than socially? If yes, how much/day?			
Do you play adult sports? List:			
Do you have a pacemaker?			
Do you have any metal in your body? Describe:			
Comments:			

LIST TOP 3 STRESSES IN EACH CATEGORY		
Physical Stress: (e.g., sitting, lifting, poor posture, orthodontics, heel lifts, jaw splint, etc.)		
1.	2.	3.
Bio-Chemical Stress: (e.g., smoke, unhealthy foods, missed meals, drugs/pharmaceuticals, not enough water, etc.)		
1.	2.	3.
Psychological Stress: (e.g., work, relationships, finances, self-esteem, etc.)		
1.	2.	3.
Spiritual Stress: (e.g., crisis of values, meaning, and purpose; joyless or misalignment of core spiritual beliefs)		
1.	2.	3.
Emotional Stress: (e.g., feelings, mood, etc.)		
1.	2.	3.

Accidents, injuries, surgeries, X-rays, trauma, procedures, hospitalizations.	Date

Optional: Share Faith Story / Experience

ADVERSE CHILDHOOD EXPERIENCE (A.C.E.)		YES
The questions below cover all ten types of A.C.E.'s and refer to the years prior to your 18th birthday. (www.nikigratrix.com)		
Did a parent or other adult in household swear at you, insult you, put you down, humiliate you or act in a way that made you afraid you might be physically hurt?		
Did a parent or other adult in household push, grab, slap or throw something at you? Or ever hit you so hard you had marks or were injured?		
Did an adult or person at least 5 years older than you ever touch or fondle you? Ever had you touch or fondle their body in a sexual way? Attempt to or actually have oral, anal or vaginal intercourse with you?		
Did you feel that no one in your family loved you or thought you were important or special? Your family didn't look out for each other, feel close to each other or support each other?		
Did you feel that you didn't have enough to eat, had to wear dirty clothes and had no one to protect you? Your parents were too drunk or high to take care of you or take you to the doctor if needed?		
Were your parents ever divorced or separated?		
Was your mother or stepmother pushed, grabbed, slapped or had something thrown at her? Kicked, bitten, hit with a fist or with something hard? Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?		
Did you live with anyone who was a problem drinker or alcoholic? Or who used street drugs or abused prescription drugs?		
Was a household member depressed or mentally ill? Did a household member attempt suicide?		
Did a household member go to prison?		
Were you bullied, taunted or shunned at school?		
Did you experience racism or homophobia or similar forms of hate abuse?		
Did you experience a serious physical trauma, illness or accident in childhood which required hospitalization?		
Did you experience a difficult or traumatic birth?		
Did you witness violence or abuse of a sibling, parent or family member?		
Did an important family member or caregiver die during your childhood?		
Did you experience homelessness during childhood?		
Did your family experience significant adverse financial events during your childhood such as loss of job, financial stability or home?		
Was there significant trauma experienced by your mother during her pregnancy with you?		
Were your parents or grandparents affected by war, political upheaval or other adverse events listed above during their lifetime?		
Would your parents/caregivers rate high on this assessment?		

Check all that apply to you:									
<input type="checkbox"/>	Traumatic birth	<input type="checkbox"/>	Clumsy	<input type="checkbox"/>	Listening issues	<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	Ear infections/surgeries
<input type="checkbox"/>	Picky eater	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	Memory issues	<input type="checkbox"/>	Negative disposition	<input type="checkbox"/>	Emotional control (+ / -)
<input type="checkbox"/>	Shyness	<input type="checkbox"/>	Childhood trauma	<input type="checkbox"/>	Sensory issues	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	Addiction(s)
<input type="checkbox"/>	Homework struggles	<input type="checkbox"/>	Low confidence	<input type="checkbox"/>	Travel sickness	<input type="checkbox"/>	Messy	<input type="checkbox"/>	Other:

HEALTH HISTORY INFORMATION: BODY AREA		Rare	Mild	Moderate	Severe
	Neck				
	Upper back				
	Lower back				
	Chest				
	Abdomen				
	Arms				
	Hands				
	Quads				
	Hamstrings				
	Calves				
	Feet				

PAIN

Describe your pain if applicable: sharp dull ache stabbing

Describe improvement since acquiring the pain: same improving worse

Does the pain travel or radiate: yes no Where?

What makes it better? Worse?

Family history of this or a similar symptom? yes no Who?

Condition interferes with: work leisure sleep sports/exercise attitude other

Describe how so:

Have you needed to make any “positive” changes as a result of this condition?
(i.e., eat better, less alcohol/drugs, less destructive sports, pray, etc.) yes no

Describe how so:

CHECK ANY DISORDER YOU HAVE HAD IN LAST 5 YEARS					
CARDIOVASCULAR	NERVOUS	VASCULAR	MUSCLES	OTHER	
Heart Disease	Chronic Pain/Sciatica	Osteoporosis	Muscular Tension	Infection/Rashes/Warts	
High Blood Pressure	Shingles/Herpes	Vertebral Disc Disorders	Spasms	Asthma/Sinus	
Blood Vessel Disorder	Spinal Cord Injuries	Arthritis (any type)	Cramps	Dizziness/Ear Ringing	
Varicose Veins	MS/Parkinson’s	Sprains/Strains	Fibromyalgia	Headaches	
Bleeding Disorder	Cerebral Palsy	Tendonitis/Bursitis	Muscular Dystrophy	Digestive Discomfort	
Blood Clots	Numbness/Tingling	Carpal Tunnel	Jaw Pain/TMJ	Diabetes	
Stroke	Epilepsy	Scoliosis	Joint Stiffness	Cancer	
Cold Hands/Feet	Fatigue/Chronic Fatigue		Joint Swelling	PMS/Menopause	
Comments:					