the place for your whole being
Holistic Haven

Name:_____ Referred By: _____ Date:_____

Address: _____ City:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Birth Date:_____ Birth Time (if known): _____ Occupation: _____

Marital Status: _____ Number of Children _____ Email:_____

Personal Health Information

What is your primary health concern or main reason for coming today? _____

_____

_____

Please describe your symptoms:_____

_____

Please list any other health/problems concerns that are troubling you:_____

_____

Please list your vitamins/herbs or other natural remedies: _____

_____

_____

What prescription medications are you taking? _____

_____

Please list any previous surgeries: _____

_____

Have you had any car accidents or severe physical trauma?_____

_____

Please describe your typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Cravings:_____

Beverages:_____

How many hours of sleep do you get each night? _____

How is your sleep? _____ Difficulty falling asleep?_____ Waking in the night?_____

Do you wake in the night to urinate?_____

Do you have any complaints with your digestion? _____

How often do you have a bowel movement? _____

Please list your known allergies: _____

_____

Please describe your hormone/menstrual history: _____

_____

Please list your type & frequency of exercise: _____

What do you find stressful in your life? _____

Who lives with you? (Any pets?) _____

How would you describe your relationship(s) with your partner/children/parent(s)/employer?

_____

_____

Has there been any traumatic experience or major loss in your life?_____

_____

Where have you last traveled outside the USA?_____

Have you been exposed to toxic chemicals, paints, industrial cleaners, pesticides, orchards, golf courses?

_____

Do you have silver fillings/crowns/root canals? _____

Have you removed/replaced any mercury fillings? _____

Have you experienced reactions to any vaccinations, medications, or supplements?

_____

Family medical history: _____

_____

Are you currently under the care of an M.D. or other health care practitioners: _____

_____

Please read carefully:

- All session information is kept confidential unless otherwise requested.
- All sessions are voluntary and no medical diagnosis will be made. This is not a substitute for medical treatment.
- For best overall results, it is important to follow through on the suggestions made at your scheduled visits.
- All fees are to be paid at the time of your appointment and are non-refundable.

Patient Commitment & Missed Appointment Policy

We strive to provide you with the utmost professionalism and excellence of service. Our commitment to your wellbeing is something everyone in our center takes quite seriously.

A 24 hours notice is required for an appointment to be cancelled or rescheduled.

In an instance of cancellation without 24 hours notice or no-show to a scheduled appointment, you will be charged a $105.00 fee.

The only exception to the fee is in the case of an emergency. If repeated cancellations occur, we reserve the right to discontinue care.

In addition, some people are sensitive to scents; please refrain from wearing perfumes or colognes.

Thank you for your understanding and cooperation.

_____

Print Name

_____ _____

Signature Date