Health Assessment

Healing*Edge Sciences
7451 Warner Avenue, Suite E169
Huntington Beach, CA. 92647
(714) 847-4685 Fax (714) 848-8311

Client's Name: _____ Client Referred by: _____

Address _____ City, State & Zip _____

Telephone (best contact #) _____ E-mail address _____

Age_____ Gender _____ Marital Status _____ No. of Children _____ Age of youngest child _____

Ethnicity/Race - Father _____ Mother _____

Comments? _____

Current Height _____ Current Weight _____ Desired Weight _____ Frame Size Sm ❑ Med ❑ Lg ❑

Weight at Age 18? _____ Weight 1 year ago? _____ Weight 5 years ago? _____

Women Only: Weight prior to first pregnancy? _____ Weight 3 months after first delivery? _____

Weight after last pregnancy? _____ Did you nurse? Yes❑ No ❑ Any complications with births? Y ❑ N ❑

If yes, please briefly explain _____

Occupation _____ Employer _____

Do you consider your work/lifestyle physically - Strenuous ❑ Active ❑ Light ❑ Sedentary ❑ Dangerous? ❑

Days and Times you work? (Example: M-F from 6am-3pm) _____

Do you currently exercise? Yes❑ No ❑ How many days a week? _____ How many minutes daily? _____

What type of exercises do you perform? (Example: Curves, Cardio at Gym, Pilates with Tape, Yoga Class).
Please list all types and number of minutes each exercise takes daily _____

Notes: (Counselor only)

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Lifestyle

Counselor notes below:

Do you currently smoke? Yes❑ No ❑ If yes, how many daily? _____ If you quit, how long ago? _____

How many years of smoking? _____ Do you drink alcohol? Yes ❑ No ❑ If so, how often? _____

Do you currently use recreational drugs? Yes ❑ No ❑ If so, what type(s)? _____

_____

Prescription Medications, Non-prescription Medications, Nutritional Supplements

Please list your current daily regimen for medications and nutritional supplements. Attach an extra sheet of paper if necessary to complete. It is important that you list everything taken.

Medication or Nutritional Supplement Taken	How Long have you taken this medication?	This medication is taken for what purpose?	What exact time of the day do you take this?

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Medical History

Please list any major surgeries _____

What have you ever been diagnosed as having? _____

Please list any allergies _____

Do you have recent blood work? Yes ❑ No ❑ (Please bring recent lab work with you to your appointment.)

Family Health History

Relative	Age at death	Cause of Death	Any chronic Illnesses	Heritage/Ancestry
Maternal Grandfather				
Grandmother				
Maternal Grandfather				
Grandmother				
Father				
Mother				
Siblings				
Children				

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Health History (Residential Visitation) *Please list any visits to countries outside the United States*

Place of Visit	When (year)	How Long?	Any illness/symptoms while traveling?

Environmental Exposure *Please list previous employment or activity in which exposure to pesticides, toxic chemicals, heavy metals, cosmetics, paint, electromagnetic fields or nuclear exposure is (was) considered a part of your work.*

Job or Activity	What year (s)?	What exposure

Goals and Health Concerns *What is the primary reason you are seeking a consultation?*_____

Please list any symptoms or concerns (or goals for yourself) that have prompted you to seek counseling.

Other Concerns or Reasons for Counseling	How long have you had this concern?	What symptoms do you notice with this concern?

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Health Symptoms Questionnaire

Please circle symptoms and check box indicating the frequency of a symptom. Use the 4th box to indicate the strength of each symptom. 1= minor problem, tolerable, live with it; 2 = major problem when it occurs, requiring medication or bedrest; 3 = chronic problem that may be life-long, forces you to stop your activities, may require visit to doctor, continual medications, resulted in hospital visit or repeated treatments.

Head, Ears, Nose, Eyes	Never	Occasional	Frequent	Strength
Insomnia, sleep apnea, nocturnal fatigue, trouble getting out of bed	☐	☐	☐	☐
Headaches, dizziness, fainting, vertigo, lightheadedness, migraines	☐	☐	☐	☐
Itchy ears, earaches, ear infections, ringing in ears, drainage in ear	☐	☐	☐	☐
Watery, itchy eyes, bags or dark circles under eye, tunnel vision	☐	☐	☐	☐
Sinus infection, stuffy or runny nose, hay fever, sneezing attacks, excessive mucus	☐	☐	☐	☐

Please make comments here _____

_____

Mouth, Throat, Lungs				
Chronic coughing, gagging, need to clear throat, hoarseness, sore throat	☐	☐	☐	☐
Swollen or discolored tongue, swollen gums or lips, dental infections	☐	☐	☐	☐
Swollen glands, strep throat, bleeding gums, abnormal bad breath	☐	☐	☐	☐
Chest congestion, difficulty breathing, shortness of breath	☐	☐	☐	☐
Asthma, allergies, bronchitis, undetermined chest pain	☐	☐	☐	☐

Please make comments here _____

_____

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Digestion, Skin, Elimination

Nausea, Vomiting, Diarrhea, Constipation, Water Retention	☐	☐	☐	☐
Bloating, Belching, Passing Gas, Heartburn, Stomach/Intestinal Pain	☐	☐	☐	☐
Genital Itch or Discharge, Yeast Infections, Herpes Infections	☐	☐	☐	☐
Acne, Rashes, Hives, Shingles, Dry or Broken Skin, Excessive Sweating	☐	☐	☐	☐
Kidney infections, Prostate Inflammation, Frequent Urge to Urinate	☐	☐	☐	☐

Please make notes here _____

_____

Joints, Muscles, Energy, Pain and Inflammation

Pain or aches in joints, arthritis, limitation of movement, lower back pain	☐	☐	☐	☐
Pain or aches in muscles, fibromyalgia, feeling of weakness	☐	☐	☐	☐
Fatigue, feeling of tiredness daily, loss of libido, daily need to nap	☐	☐	☐	☐

Please make notes here _____

_____

Immunity

Frequent colds or flu, seasonal allergies	☐	☐	☐	☐
Toenail infections, Skin Fungus, Hepatitis, HIV or other viruses	☐	☐	☐	☐
Cancer (current or remission), lymphatic issues, transplant	☐	☐	☐	☐

Please make notes here _____

_____

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Heart, Circulation

Irregular or skipped heartbeat, rapid or pounding heartbeat	☐	☐	☐	☐
Blood pressure, high cholesterol, heart muscle concern, clotting issues	☐	☐	☐	☐
Cold hands or feet, easy bruising, varicose veins, erectile dysfunction	☐	☐	☐	☐

Please make notes here _____

_____

Weight, Metabolic Activity, Brain Function

Binge eating or drinking, craving certain foods, compulsive eating	☐	☐	☐	☐
Underweight, eating disorder, loss of appetite, yo-yo dieting	☐	☐	☐	☐
Hyperactivity, apathy, lethargy, restlessness, sluggishness, confusion	☐	☐	☐	☐
Memory loss, poor concentration, difficulty making decisions, fear, anxiety	☐	☐	☐	☐
Mood swings, nervousness, anger, irritability, aggressiveness, depression	☐	☐	☐	☐

Please make notes here _____

_____

Female Transitions

Breakout bleeding, excessive hair, bloating, irregular period, loss of menses	☐	☐	☐	☐
Lack of libido, night sweats, hot flashes, hormone replacement therapy	☐	☐	☐	☐
Vaginal discharge, dryness, breast tenderness, underarm pain	☐	☐	☐	☐
Cosmetic surgery, breast enhancement or reduction, botox or collagen injections	☐	☐	☐	☐

Please make notes here _____

Please read each section carefully and sign before appointment:

Healing*Edge Sciences does not share any information provided by clients unless clients request in writing for caregivers, family members, other practitioners or interested parties to receive such confidential information. Healing*Edge Sciences Consulting provides integrative counseling only and does not practice allopathic medicine. The intent of our services is to educate clients on proper nutrition for quality of life, as well as provide education in practical methods of obtaining optimal health. Healing*Edge Sciences does not provide medical services, including but not limited to diagnosis, treatment, cure or mangement of any illness or disease.

Please initial here that you have read and understand the above notice. _____

Please expect your consultation to last as long as it takes to find answers. The cost for an initial visit is $475.00, which includes the health assessment, safety check on medications and/or nutritional supplement, an in-depth consultation, a resulting personalized meal plan and structured follow-up interaction to last for three weeks. This cost does not include nutritional products, which may be recommended.

Please provide your signature here indicating that you have read and understand the above notices regarding our services.

Signature _____

Date _____

IMPORTANT NOTICE: Any client using medications and/or nutritional supplements should list these products in their assessment.

Please initial that you have read and understand the above notice. _____

All credit cards will be processed through Scientific Bio-Logics - Please expect this billing name to show up on your statement.

After filling out the assessment, please fax it to the number at the top of these 8 pages. You can also email it back to help@healingedge.net