Mind Body Spirit, Reformers LLC

Personalized Health Profile

Please fill this form out as detailed as you possible can. it will help tremendously to get to the root cause.

Personal Information

Demographics

First name

Last name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Relationship status

Occupation

Hours per week

Referred by

Age

Height

Place of Birth

Prioritization and Goal Setting

Specific Areas You Are Interested In (Prioritize 3)

- [ ] Stress
- [ ] Fatigue
- [ ] Health Concerns- Be specific below
- [ ] Weight Loss
- [ ] Confidence
- [ ] Nutrition
- [ ] Exercise
- [ ] Mental and Emotional Wellbeing
- [ ] Spiritual Healing
- [ ] Other- List Below

Specify Here:

Please tell us about the goals you hope to accomplish- Top 3 and Explain

Communication Style

What is your favorite way to communicate? Check all that apply

- [ ] In Person
- [ ] Text
- [ ] Email
- [ ] Phone Call
- [ ] Video Chat
- [ ] Other

Which social media platforms do you use if any? Check all that apply

- [ ] Facebook
- [ ] Twitter
- [ ] Other
- [ ] Instagram
- [ ] LinkedIn

Lifestyle

Current Weight

Weight 6 months ago

Weight a year ago

Would you like your weight to be different? If so what?

What is your occupation and how many hours per week do you work?

Please list your main health concerns?

When was the last time you felt really vibrant and well?

Other major health concerns?

If you could wave a magic wand and change two things about yourself right now, what would they be?

Hospitalizations or Surgeries? If so, please explain with dates

Any serious illnesses and/or injuries, now or in the past? Please explain

How many hours of sleep do you get at night?

Do you sleep well at night? If not please explain why?

Do you have vivid dreams at night that you remember?

Do you consume alcohol? If so, how much?

Have you ever smoked tobacco now or in the past? Explain?

Family History

What is your ancestry?

How is the health of your mother? If deceased, please relay illnesses and reason.

How is the health of your father? If deceased, please relay illnesses and reason

Any family affected by the following? Check all that apply and explain who below

- ☐ Heart Disease/Heart Attack
- ☐ Cancer- Malignancy- Be specific below
- ☐ Thyroid Problems
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Allergies/Asthma
- ☐ Prostate Cancer
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Bleeding/Clotting Problems
- ☐ Breast Cancer
- ☐ Hepatitis
- ☐ Depression/Anxiety
- ☐ Other Mental Health Issues- Be specific below

Specify Answers from Above Here

Personal Medical Information

Please check if you have/had any of the following medical conditions and explain any checks below.

- ☐ Heart Disease/Heart Attack
- ☐ Cancer- Malignancy- Be specific below
- ☐ Thyroid Problems
- ☐ Seizures
- ☐ High Blood Pressure
- ☐ Allergies/Asthma
- ☐ Prostate Cancer
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Bleeding/Clotting Problems
- ☐ Breast Cancer
- ☐ Hepatitis
- ☐ Depression/Anxiety
- ☐ Other Mental Health Issues- Be specific below

Specify Answers from Above Here

Any ongoing sources of inflammation (i.e. eczema or other skin irritation, chronic post nasal drip, congestion, headaches, achy/muscle joints, swelling, pain stiffness)?

Do you struggle with Constipation, Diarrhea, Gas, Distention, Belching, Bloating? Which one and When does it occur?

Physical Activity

How often do you participate in physical activity?

- ◯ Never
- ◯ 1-3 times a month
- ◯ 1-2 times a week
- ◯ 3-5 times a week
- ◯ Other

If "Other", please specify

When doing physical activity, how long do you remain active?

- ◯ N/A
- ◯ 20 Minutes
- ◯ 30 Minutes
- ◯ 1 hour
- ◯ More than 1 hour
- ◯ Other

If "Other", please specify

At what intensity are you physically active? Choose your ability to talk during exercise?

- ◯ N/A
- ◯ Able to talk
- ◯ Able to talk but not sing
- ◯ Not able to say more than a few words
- ◯ Other

If "Other", please specify

Do you know people that schedule their activity time are likely to be more active? ◯ Yes ◯ No

What time of day works for you to be active?

Did you know people who are active with a partner are more likely to be consistently active? ◯ Yes ◯ No

Who is a potential workout partner for you?

Will you be willing to ask them to be active with you? ○ Yes ○ No

Medication and Supplement History

Please list ALL supplements or medications you take (prescription or over-the-counter) dose and frequency?

Name of Medication	Dose	How often do you take it?	When do you take it?

Have you ever taken antibiotics more than a short course or two as a child? If so, when/how often? For what? And for how long?

Medical/Toxin Exposure History

Any remarkable exposure to toxins (e.g. current or childhood home, nearby industrial community, job, hobbies, travel, pesticides, heavy metals)?

What is the general status of your dental health/care?

Any troubling dental work or history of dental/oral infections? Dentures? Root canals?

How many silver/mercury fillings do you have?

Other major dental work/issues beyond basic cleanings?

On a scale of 1 to 10, how would you rate your general energy level (1=lowest)?

To what do you attribute this energy level?

Healers and Stress History

Any healers, helpers, pets or therapies with which you are involved?

What are your primary hobbies?

What role do sports and exercise play in your life?

What do you do to relax? How often?

What was your general health and well-being as a child? Be specific with details

Nutrition History

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you have any known food allergies or sensitivities?

What percentage of your food is home-cooked?

What percentage is not?

Where do you get the rest from?

If you have a general philosophy, mindset or approach you use when choosing foods, please describe it briefly.

Do you crave sugar, carbs, alcohol, coffee, cigarettes, other foods, or have any addictions?

This Section for Women Only

Age when you first got your period?

Are your periods regular? ○ Yes ○ No

Please explain

How many days is your flow?

How frequent?

Painful or symptomatic? ○ Yes ○ No

Please Explain

Birth control history

Vaginal infections, reproductive concerns?

This Section is For Men Only

Last time your PSA was checked?

Do you wake up at night to urinate constantly? ○ Yes ○ No

Please Explain

When you urinate do you feel you still have more to empty?

Any concerns with your reproductive organs (i.e. testicles,, scrotum etc)? Please be specific when answering

Sexual History

Are you currently sexually active? ○ Yes ○ No

How many partners currently?

Do you prefer a male partner or a female partner or both?

Any issues with libido? ○ Yes ○ No

Please explain

Any difficulty achieving an orgasm? ○ Yes ○ No

Please Explain

Anything else in your sexual history that you would like to share? ○ Yes ○ No

Please Explain

Past Surgical and Injury History

Any surgeries in the past? ○ Yes ○ No

Please explain when it was done, what body area and what caused you to have surgery?

Do you currently have or have you had any injuries or illnesses in the last 6 months? ○ Yes ○ No

Please describe when and how it started

Are you healed or feel better from any injuries or surgeries in the past? ○ Yes ○ No

What currently are you doing to feel better?

Did you see a medical professional? ○ Yes ○ No

Who and how often?

Are you currently getting treatment? ○ Yes ○ No

What type of treatment and how often? Is it helping?

What two single changes do you most know you need to make in order to get healthier and reach your specific goals?

What specifically stands in the way of your making the healthier choices that you know would serve you the best?

Imagine what it will be like when you reach your specific health goals. What will this allow to happen in your life? Please give two specific benefits you are particularly excited about.

Many of our client's health situations are complex and have already been investigated by several other practitioners. Sometimes the most important ah-ha in uncovering what you are struggling is an unexpected or unconventional concept. Intuitively, what do you feel is the most important pearl of information we need to understand about how or why your health is in the state that it is right now?

Anything else you would like to share?

Symptom Questionnaire

Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two years. If multiple choices are given, please specify what applies in the comment column. Leave the score blank if you Never have the symptom. Use a 1 if you Occasionally have it and the effect is Mild. Use a 2 if you Occasionally have it and the effect is Severe. Use a 3 if you Frequently or Consistently have it and the effect is Mild Use a 4 if you Frequently or Consistently

CATEGORY	Symptom	Score	Comments or Details, if applicable
HEAD	☐ Headache		
	☐ Faintness		
	☐ Dizziness		
	☐ Insomnia		
NOSE	☐ Stuffy Nose		
	☐ Sinus Problems		
	☐ Hay Fever		
	☐ Sneezing Attacks		
	☐ Excessive mucus formation		
MOUTH	☐ Chronic coughing		
	☐ Gagging or frequent need to clear throat		
	☐ Sore throat, hoarseness, or loss of voice		
	☐ Swollen or discolored tongue, gums, or lips		

	☐ Chronic tooth or gum pain or jaw pain. Which?		
	☐ Canker sores		
SKIN	☐ Acne		
	☐ Hives or other allergic breakout		
	☐ Rash or persistently dry skin		
	☐ Hair loss		
	☐ Flushing or hot flashes		
	☐ Frequently feel cold		
	☐ Excessive sweating		
	☐ Part of body frequently feeling numb. Which?		
HEART	☐ Irregular or skipped heartbeat		
	☐ Rapid or pounding heartbeat		
	☐ Chest pain		
LUNGS	☐ Chest congestion		
	☐ Asthma, bronchitis		
	☐ Shortness of breath		

	☐ Difficulty breathing		
DIGESTION	☐ Nausea or vomiting		
	☐ Diarrhea		
	☐ Constipation		
	☐ Bloated feeling		
	☐ Belching, burping		
	☐ Passing gas, flatulence		
	☐ Heartburn		
	☐ Intestinal or Stomach pain. Which?		
	☐ Other pain in GI tract? Where?		
JOINTS AND MUSCLES	☐ Pain or aches in joints		
	☐ Arthritis		
	☐ Stiffness or limitation of movement		
	☐ Pain or aches in muscles		
	☐ Tremor or restless leg		
	☐ Feeling of weakness or tiredness		
WEIGHT	☐ Binge eating/drinking		

	☐ Craving certain foods		
	☐ Excessive weight		
	☐ Compulsive eating		
	☐ Water retention		
	☐ Underweight		
ENERGY	☐ Fatigue, sluggishness		
	☐ Apathy, lethargy		
	☐ Hyperactivity		
	☐ Restlessness		
MIND	☐ Poor memory		
	☐ Confusion, poor comprehension		
	☐ Poor concentration or focus		
	☐ Poor physical coordination		
	☐ Difficulty in making decisions		
	☐ Stuttering or stammering		
	☐ Learning disabilities		
MOOD	☐ Mood swings		
	☐ Anxiety, fear, nervousness		

	☐ Anger, irritability, aggressiveness		
	☐ Depression		
	☐ Other mood challenges?		
OTHER	☐ Frequent illness		
	☐ Frequent or urgent urination		
	☐ Inability to urinate or low urine flow		
	☐ Low libido or other sexual dysfunction		
	☐ Genital itch or discharge		
	☐ Women: Breast fibroids		
	☐ Women: Painful or tender breasts		
	☐ Women: Uterine fibroids		

Please tally up the score and place your total symptom score here

Any further comments you wish to share?

Client

I have read and understood the above.

X

Print Name: **Date:**