

**Wind Touch Healing, L.L.C.**  
**Patient Health History**

Name: \_\_\_\_\_  
(first) (middle) (last)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_\_

Gender: M/F

Marital status: S M D W

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.*

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Has your case been referred to an attorney?      Y      N

3. Please identify the health concerns that have brought you to the clinic in order of importance below:

**Condition**

**Past Treatment**

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

d. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

\_\_\_\_\_  
\_\_\_\_\_

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you have any reason to believe you may be pregnant?      Y      N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases?      Y      N      If yes, please identify: \_\_\_\_\_

<b>8. Family History:</b>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_/\_\_\_\_\_ When was this reading taken? \_\_\_\_\_

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):  
 Mood Swings                  Nervousness                  Mental Tension                  Anxiety                  Depression
16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):  
 Fatigue                  Slow Wound Healing                  Chronic Infections                  Chronic Fatigue Syndrome  
 Refreshed in the Morning: Y N    Does Energy Drop During the Day: Y N ( If Yes, What Time of Day: \_\_\_\_\_am/pm)
17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):  
 Impaired Vision                  Eye Pain/Strain                  Glaucoma                  Glasses/Contacts                  Tearing/Dryness  
 Impaired Hearing                  Ear Ringing                  Earaches                  Headaches                  Sinus Problems  
 Nose Bleeds                  Frequent Sore Throats                  Teeth Grinding                  TMJ/Jaw Problems                  Hay Fever
18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):  
 Pneumonia                  Frequent Common Colds                  Difficulty Breathing                  Emphysema  
 Persistent Cough                  Pleurisy                  Asthma                  Tuberculosis  
 Shortness of Breath                  Other Respiratory Problems: \_\_\_\_\_
19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):  
 Heart Disease                  Chest Pain                  Swelling of Ankles                  High Blood Pressure  
 Palpitations/Fluttering                  Stroke                  Heart Murmurs                  Rheumatic Fever                  Varicose Veins
20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):  
 Ulcers                  Changes in Appetite                  Nausea/Vomiting                  Epigastric Pain                  Passing Gas                  Heartburn  
 Belching                  Gall Bladder Disease                  Liver Disease                  Hepatitis B or C                  Hemorrhoids                  Abdominal Pain  
 Bloating                  Difficulty Swallowing                  # of Bowel Movements per day\_\_\_\_\_                  Color of Stool\_\_\_\_\_
- Stool Smell Foul: Y N    Length of Stool\_\_\_\_\_                  Shape of Stool:    Formed    Hard    Diarrhea    Alternating
21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):  
 Kidney Disease                  Painful Urination                  Frequent UTI                  Frequent Urination                  Heavy Flow  
 Kidney Stones                  Impaired Urination                  Blood in Urine                  Frequent Urination at Night  
 Color of First Urination: Clear    Light Yellow    Dark Yellow    Cloudiness: Y N    Difficulty Starting Flow: Y N  
 Any Pause in Urination: Y N
22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):  
 Irregular Cycles                  Breast Lumps/Tenderness                  Nipple Discharge                  Heavy Flow  
 Vaginal Discharge                  Premenstrual Problems                  Clotting                  Bleeding Between Cycles  
 Menopausal Symptoms                  Difficulty Conceiving                  Painful Periods  
 Are you satisfied with your Libido? Y N                  Sexually active how many times per week: \_\_\_\_\_
23. **Menstrual/Birthing History:**  
 1. Age of First Menses: \_\_\_\_\_                  4. Birth Control Type: \_\_\_\_\_                  7. # of Abortions: \_\_\_\_\_  
 2. # of Days of Menses: \_\_\_\_\_                  5. # of Pregnancies: \_\_\_\_\_                  8. # of Live Births: \_\_\_\_\_  
 3. Length of Cycle: \_\_\_\_\_                  6. # of Miscarriages: \_\_\_\_\_
24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):  
 Sexual Difficulties                  Prostrate Problems                  Testicular Pain/Swelling                  Penile Discharge  
 Do you have ED? Y N                  Trouble having an Erection: Y N                  Trouble maintaining Erection: Y N  
 Are you satisfied with your Libido? Y N                  Ejaculation how many times per week\_\_\_\_\_
25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):  
 Neck/Shoulder Pain                  Muscle Spasms/Cramps                  Arm Pain                  Upper Back Pain                  Mid Back Pain  
 Low Back Pain                  Leg Pain                  Joint Pain (if so, where?): \_\_\_\_\_
26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):  
 Vertigo/Dizziness                  Paralysis                  Numbness/Tingling                  Loss of Balance                  Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):  
Hypothyroid    Hypoglycemia    Hyperthyroid    Diabetes Mellitus    Night Sweats    Feeling Hot or Cold

28. **Skin** (please circle any that you experience now and underline any that you have experienced in the past):  
Dry    Clammy    Moles    Skin Tags    Age Spots    Warts    Eczema    Rashes

Scars: Y N Locations: \_\_\_\_\_

**Nails** Ridges    Moons    Color    Shape    **Toe Nails** Ridges    Moons    Color    Shape

29. **Other** (please circle any that you experience now and underline any that you have experienced in the past):  
Anemia    Cancer    Hives    Psoriasis    Other: \_\_\_\_\_  
Is there anything else we should know? \_\_\_\_\_

30. **Lifestyle:**

a. How many glasses of water do you drink per day? \_\_\_\_\_

b. What temperature do you drink fluids at: With ice    Cold    Room Temp    Hot

c. How many sodas per day? \_\_\_\_\_ How many glasses juice per day? \_\_\_\_\_ Cups of Coffee/day? \_\_\_\_\_

d. Nicotine/Alcohol Use: \_\_\_\_\_

e. Do you typically eat at least three meals per day? Y N If no, how many? \_\_\_\_\_

f. Do you typically snack? Y N List snacks \_\_\_\_\_

g. Exercise routine: \_\_\_\_\_

h. Spiritual practice: \_\_\_\_\_

i. How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? Y N

j. Time you go to bed? \_\_\_\_\_ a.m. / p.m. Time you wake up \_\_\_\_\_ a.m. / p.m. Trouble falling asleep Y N  
Trouble staying asleep? Y N

k. Level of education completed: High School    Bachelors    Masters    Doctorate    Other

l. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Do you enjoy work? Y N Why / Why not? \_\_\_\_\_

m. Have you experienced any major traumas? Emotional    Physical    Sexual    Neglect

Explain: \_\_\_\_\_

n. Television habits: \_\_\_\_\_ Reading habits: \_\_\_\_\_

o. Interests and hobbies: \_\_\_\_\_

How did you hear about us? _____
To receive our email newsletter please list your email _____