# Confidential Case History

Date: _____

Name: _____

Email Address: _____

Address: _____

City: _____ Prov: _____ Postal Code: _____

Home Phone: _____Bus. Phone: _____ Cell Phone: _____

Date of Birth: _____ Occupation: _____

Medical Doctor: _____ Doctor's Phone: _____

Please list any other therapies that you are currently undertaking:

_____

Who referred you to me? _____

Are you in good health? Yes No

Have you had any surgeries? Yes No If yes, please list type of surgery and approx. date:

_____

_____

Have you ever had accidents/injuries of any type? Yes No If yes, please describe and give approx. Date

_____

_____

Have you had any serious illnesses? Yes No

If yes, please give details _____

Are you currently taking any prescription drugs, recreational drugs, herbs, vitamins, natural products,

or supplements? Yes No If yes, please list:

_____

_____

Do you have any allergies? Yes No If yes, please list: _____

Do you sleep well? Yes No

Please rate your current stress level on a scale from 1-10 (10 being the highest level) _____

What is your main source of stress? _____

Your main concern or reason for this session today is:

_____

_____

When did this issue or condition begin? _____

What do you hope this session will accomplish for you?

_____

_____

What are you currently doing to maintain your health? (exercise, healthy eating, meditation, spiritual retreats etc.)

_____

_____

How many bowel movements do you usually have per day? _____

Do you smoke? Yes No

Do you wear glasses, contacts, metal plates, pins or wires, dentures or a hearing aid? (circle all that apply)

What is your current water consumption per day? _____

Are you currently using a particular diet, fast, or cleanse? Yes No

What does your current daily menu consist of? (in general)

| | |
|---|---|
| **Breakfast** | |
| **Lunch** | |
| **Dinner** | |
| **Snacks** | |

Please indicate the consumption level of the following:

| | None | Light | Moderate | Heavy |
|---|---|---|---|---|
| **Salt** | | | | |
| **Sugar** | | | | |
| **Caffeine** | | | | |
| **Tobacco** | | | | |
| **Alcohol** | | | | |

Please indicate (circle) if you currently have or have ever had any of the following conditions:

| | |
|---|---|
| Abdominal Pain | Constipation |
| Acid Reflux/Indigestion | Cough |
| Anemia | Depression |
| Angina | Diabetes |
| Arthritis | Diarrhea |
| Asthma | Digestive Disorder |
| Back Pain | Dizziness |
| Bladder Infections | Ear/Hand/Foot Problems |
| Bloating or Gas | Eyes –Vision Problems |
| Bowel Disorders | Emotional Disorders |
| Bronchitis | Fibromyalgia |
| Bursitis | Gall Stones |
| Cancer | Glandular Disorders |
| Chest Pain | Gout |
| Chronic Fatigue | Headaches/Migraines |
| Circulation Problems | Hearing Loss/Problems |
| Cold Hands/Feet | Heart Disease/Murmur |

| | |
|---|---|
| Colds (frequent) | Heart Palpitations |
| Hemophilia | Osteoporosis |
| Hepatitis | Pins & Needles |
| Herpes | Prostate Problems |
| High/Low/Erratic Blood Pressure | Reproductive Disorders |
| Hypoglycemia | Respiratory Conditions |
| Hypo/Hyperthyroidism | Scoliosis |
| Immune System/Lymphatic | Shortness of Breath |
| Joint/Bone Disorders | Sinus Problems |
| Kidney or Liver Disease | Skin Disorders (warts, eczema, etc...) |
| Kidney Stones | Sleep Disorders |
| Mental Disorders | Stress/Trauma |
| Muscle Disorders | Tropical Illness |
| Nausea/Vomiting | Tuberculosis |
| Nerve Pain/Damage | Ulcers |
| Nervous Disorders | Urinary Disorders |
| Numbness/Tingling | Varicose Veins |

Any additional information that you would like to share:

_____

_____

## For Women Only:

Are you pregnant or trying to achieve pregnancy? Yes No

Number of weeks _____

Have you had any previous pregnancies? Yes No If yes, how many? _____

Were there any complications? Yes No If yes, please explain:

_____

Do you have any menstrual or menopausal problems? Yes No If yes, please explain:

_____

What is the regularity of your menstrual cycle? Regular Irregular (unpredictable)

If regular, how often? _____ (ex. every 28 days)

Are you currently using any contraceptive methods? Yes No If yes, what? _____

Do you experience symptoms of PMS? Yes No

Any other issues to mention? (endometriosis, fibroids, etc...)

_____

# Statement of Consent

I hereby certify that the information in this case history is accurate, complete, and up to date, and release Dayna Boetzkes (the therapist) from any and all liability due to problems arising from therapy as a result of information not given or incorrectly given in this case history. I also agree to advise the therapist of any relevant conditions that may arise or change during the course of treatment.

Signature: _____ Date: _____

**For Therapist Use Only:**

Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____