**HEALTH HISTORY FORM**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY: Please check all that apply either current or past history.**

□ Allergies □ Depression □ Open Wound □ Skin/Bacterial Infection

□ Aneurysm □ Edema □ Osteoarthritis □ Surgical Procedure

□ Bleeding □ Heart Disease □ Osteopenia □ Tendonitis

□ Blood Thinners □ Hematoma □ Phlebitis □ Thrombosis

□ Bursitis □ High Risk Pregnancy □ Prenatal Toxemia □ Umbilical Hernia

□ Cancer Diagnosis □ Hospitalization □ Prescribed Cortisone □ Uncontrolled Asthma

□ Chronic Fatigue □ Injection Site □ Prescribed Vitamin A □ Uncontrolled Hypertension

□ Chronic Illness □ Liver Disease □ Prescribed Psychotics □ Varicose Veins

□ Dialysis Treatment □ Major Injury □ Rheumatoid Arthritis □ Warts/Boils

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIFIED AREAS OF CONCERN – Please check any that apply.**

□ Cranium □ Sinus Pressure □ Cervical Spine □ Thoracic Spine

□ Arm Pain □ Chest Pain □ Abdominal Pain □ Hip Pain

□ Lumbar Spine □ Sciatic Pain □ Varicose Veins □ Ankle Pain

□ Foot Pain □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BODY SYSTEM SUPPORT: Please check any that apply and/or fill-in the blank.**

☐ **Respiratory** (COPD, seasonal allergies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Integumentary** (skin, hair, nails) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Circulatory** (heart, blood, lymph drainage) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Immune** (infection defense, pro-active immune support) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Musculoskeletal** (muscle soreness, arthritis, osteoporosis, tendon, ligaments, fascia connective tissue)

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

**BODY SYSTEM SUPPORT: Please check any that apply and/or fill-in the blank.**

☐ **Metabolic Health** (glycemic level, collagen support, appetite control, increase energy) \_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Nervous** (sympathetic/parasympathetic, rest & digest, brain health, memory) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Digestive** (gut health, pre & probiotics, whole foods) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Reproductive** (peri or menopause symptoms, painful periods) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Endocrine** (hormone balance, glands, detox) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERMISSIONS – Please mark Yes or No after each question.**

1. With any of the above issues/conditions marked as a concern or condition, do I have your permission to address these issues with a holistic approach by incorporating supplements & essential oils? \_\_\_\_\_\_

2. **If yes**, do I have your permission to send a recommended protocol to your email address? \_\_\_\_\_\_\_\_\_\_

3. Do I have your permission to contact you in 3-5 business days to review protocol options? \_\_\_\_\_\_\_\_\_\_

4. During your protocol review, do I have your permission to send samples home with you? \_\_\_\_\_\_\_\_\_\_\_

5. After working with the samples for 5 days, would you communicate your results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AROMATIC PREFERENCE(S) – Please mark aromatic preference(s).**

☐ MINTS ☐ FLORALS ☐ CITRUS ☐ HERBAL

☐ EARTHY ☐ WOODSY ☐ SPICY ☐ RESONOUS

**SUPPLEMENT(S) – Please mark supplement(s) currently taking.**

☐ OMEGA 3/6 ☐ WHOLE FOODS ☐ GENERAL VITAMINS ☐ MINERALS

☐ BONE NUTRIENT ☐ PHYTOESTROGEN ☐ BODY DETOX ☐ PREBIOTIC

☐ PROBIOTIC ☐ PRENATAL VITAMINS ☐ ANTI-INFLAMMATORIES

**POLICIES AND AGREEMENT –** In consideration for becoming a CLIENT of Holistic Health Services (HHS), I agree to and acknowledge the following ASSUMPTION OF RISK AND RELEASE OF LIABILITY AGREEMENT:

1. If the following symptoms occur at arrival of HHS or during my appointment, the HHS will discontinue my appointment, at no charge. If ailments, medications or pre-existing conditions are not disclosed at the time of CLIENT appointment(s), HHS is NOT HELD LIABLE for any issues or problems arising after appointment.

* Severe coughing, sniffling or sneezing, temperature at or above 100.4˚, body aches or chills
* Open wounds, lesions, abrasions or infected skin
* Deep vein thrombosis or blood clotting with anti-coagulant medications such as: Heparin, Apixaban (Eliquis), Dabigatran (Pradaxa), Edoxaban (Savaysa), Enoxaparin (Lovenox), Rivaroxaban (Xarelto), Warfarin (Coumadin)
* High risk pregnancy without doctor’s release or pregnancy toxemia

2. I fully understand and appreciate both the known and potential risk factors of using the HHS facilities (bathroom, reception area, treatment room), equipment (table, chairs), and services and acknowledge that the use thereof by me may, despite the HHS’s reasonable efforts to mitigate such dangers, result in exposure to any flu viruses or contagions.

3. I understand and acknowledge that the HHS cannot guaranty my safety or immunity from ANY flu viruses, contagions, or flu-like infections. If I feel ill or develop any of the symptoms mentioned above, I will cancel my appointment.

4. In compliance with ADA and CDC, eye, nose or mouth protection (PPE) MAY be worn inside or outside HHS premises, by CLIENT or HHS. Should CLIENT or HHS choose not to wear PPE, the CLIENT or HHS will understand the implications of a health condition, exemption status, covid-19 negative status, or personal choice, which prevents me from wearing one. CLIENT reserves the right not to enter or have services performed at HHS. HHS reserves the right to refuse service(s), for any reason, at any time.

5. As a sovereign individual, the HHS is not responsible for your health or in charge of your personal, or medical needs. In the event of an emergency, HHS will call 911. HHS is certified in CPR and basic FIRST AID and should the occasion arise, I will allow HHS to mitigate the emergency until medical help arrives and emergency contact will be made aware of emergency.

6. I have carefully read, understand and fully AGREE to the terms of the ASSUMPTION OF RISK AND RELEASE OF LIABILITY AGREEMENT. By signing below, you acknowledge the above information is true, to the best of your knowledge, and the policies held for HHS appointments and I agree to and acknowledge the ASSUMPTION OF RISK, AND RELEASE AND WAIVER OF LIABILITY AGREEMENT.

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

CLIENT SIGNATURE DATE SIGNED

**PARENTAL CONSENT:** If CLIENT is under the age of 18, a Parent or Guardian must sign below, giving HHS permission for minor to receive treatments and discuss protocols with parent/guardian.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE DATE SIGNED

Holistic Health Services

Sherry Weldon, Holistic Health Practitioner

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