THE B.O.S.S. GROUP LLC

PERSONAL HEALTH HISTORY

Last Name:_____ First Name: _____Date:_____
Address:_____ City: _____ State:____ Zip: _____
Home/Work phone:_____ Cell phone:_____
Email address to communicate through:_____
Date of Birth: _____Age: _____Place raised:_____
Did you grow up in a home with lead pipes? Yes ☐ No ☐
Married ☐ Single ☐ Divorced ☐ Significant Other ☐ Widow ☐
Height: _____Weight:_____ Desired weight: _____ Sensitivities:_____
Occupation:_____Employer:_____
Emergency Contact: _____ Relationship: _____Phone_____
Referred By: _____
Social Security # (only if we need to process with insurance):

Are you currently under a doctor's care? _____For what? _____
Current Practitioner(s)/Physician(s):
Name:_____Address:_____Phone:_____
_____ _____ _____
What are your 3 main complaints/challenges today: (physical, emotional, pain, etc)

1. _____
2. _____
3. _____

Do you have any moral, religious, or personal value systems that dictate how and what you eat? Please describe.
Yes ☐ No ☐ _____

Stressors in your life: (Rate stress level 1-10; Ten is the worst.)
Family: _____ Social: _____Work related:_____ Stress in your body? _____Other? _____
Where do you hold your tension? _____
Do you exercise? Yes ☐ No ☐ What? _____How often? _____
Energy level and pattern? (**least and most productive time of day**)
LEAST: _____MOST:_____

Are you pregnant? _____Due date: _____

ANY physical injury to the brain or head in your lifetime (i.e. whiplash, sports concussion, head injury, falls, head butts, physical trauma, forcible bump)?_____
_____

Current Medical Concerns:

☐ Gas on stomach or in bowels
☐ Sudden change in hair texture, color
☐ Sudden weakness of eyes
☐ Development of various hernias
☐ Confusion – difficult to make even simple decisions
☐ Muscle weakness and cramps
☐ Tired feeling most of the time
☐ Extreme mental depression

Questions or concerns: LaShay Canady, BS, CCWFN, MS ~ 303.886.0673 (cell) ~ 720.372.2676 (fax)
www.thebossgrp.net ~ herbalist@thebossgrp.net

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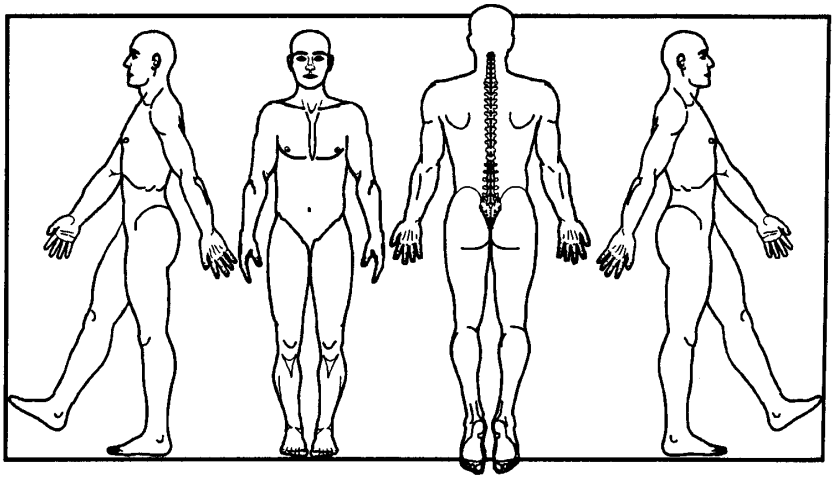
☐ Other medical concerns or **previous surgeries** (specify):

_____

_____

_____

***Mark any area of concerns on chart (This can include pain)**



Family history:

☐ Alcoholism ☐ Alzheimer's at what age_____ ☐ Anxiety ☐ Depression ☐ IBS ☐ Atherosclerosis
☐ Autoimmunity ☐ Early menopause ☐ Insomnia

List other family conditions:
☐ Allergies ☐ Diabetes ☐ Emphysema ☐ Heart disease ☐ Asthma ☐ High blood pressure ☐ Mood Disorders
☐ Migraines ☐ Attention deficit ☐ Obesity ☐ Osteoporosis ☐ Strokes ☐ Autism ☐ Thyroid disorders
☐ Osteoarthritis ☐ Cancer **list types:**_____

Average Wellness Continuum

Please circle where you think you fall on this wellness continuum

Sick **Your optimum health**

Sick most of the time	**Getting sick or better**	**OK**	**Good**	**Excellent**

Willingness to make changes

Please circle where you think you fall on this change continuum

Nothing **What it takes to get better**

Continue to live as I have	**Change lifestyle**	**Change diet**	**Change nutrition**	**Change lifestyle, diet, and nutrition**

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Sleep pattern:

☐ Average hours of sleep per night_____ ☐ Quality of sleep (circle): Good Fair Poor

☐ Insomnia? What time do you wake up? _____ ☐ Difficult getting to sleep? ☐ Yes ☐ No

Teeth:

Do you have any missing teeth? ☐ Yes ☐ No If yes, how many?:_____

Any root canals? ☐ Yes ☐ No Any mercury fillings? ☐ Yes, how many?____ ☐ No

Date of last dental care? _____ What needed/needs to be done? _____

Relationships with food/beverages/life habits:

☐ Sugar ☐ Carbohydrates ☐ Alcohol ☐ Fast food ☐ Caffeine ☐ Salt ☐ Tobacco

How long have you felt addicted?_____

When was the last time you felt well:_____

Anything you want to share I did not ask about? :_____

****Reminder: Bring/have all of your prescription medications, over-the-counter medications, herbs, supplements.

THE SMALL PRINT

Cancellation Policy:

_____ **(initial)** So that I may better serve my clients, appointments must be cancelled 24 hours in advance. If an appointment is cancelled less than 24 hours in advance (and we are unable to fill your appointment slot), or the appointment is forgotten (client does not come or call), there will be no charge the first time. After the first time, the normal fee will be charged.

Disclaimer:

_____ **(initial)** I understand that this work does not constitute nor it is a substitute for medical treatment, but rather is a form of health maintenance. I realize that this Holistic Health Practitioner/certified Clinician of Whole Food Nutrition is not a doctor, and does not diagnose, prescribe or treat any specific conditions but rather embraces the philosophies and laws of nature advocated by nutritional pioneers as Drs. Royal Lee, Melvin Page, Francis Pottenger Jr, and Weston A. Price.

Accountability:

_____**(initial)** I understand and agree that I am responsible for keeping my Holistic Health Practitioner informed of any changes in my physical condition, as this could affect the Report of Findings we discussed.

Signature:_____Date:_____

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