Healing Unleashed®

Taking you to a Healthier Place... *Naturally!*

Brain-Body Health Inventory

3609 S. Wadsworth Blvd. Suite 132
Lakewood, Colorado 80235
(303) 986-0492
fax (303) 986-0486
www.healingunleashed.com

Please Complete and Email this Form to: info@HealingUnleashed.com

General Patient Information

Today's Date _____
Name _____
Preferred Name _____
Primary Street Address _____
City:_____State_____Zip_____
Phone Cell_____ Home_____ Work_____
Email Address_____

Date of Birth _____ Gender ☐ Female ☐ Male
Genetic Background ☐ African ☐ Asian ☐ European ☐ Mid Eastern
☐ Native American
Height_____ Weight_____

☐ Single ☐ Married ☐ Divorced ☐ Significant Other
Living Situation (ie Assisted Living, etc) _____

Highest Education Level ☐ High School ☐ College ☐ Post Grad Occupation
_____
Previous Occupation _____

Emergency Contact Name _____
Phone _____Relationship _____
Family Physician _____
Address _____
Holistic Practitioner _____
Address _____
Referred by _____

Family History

Relative	Age	Problems (Or cause of death)	Children	Age	Problems (Or cause of death)
Father					
Mother					
Siblings					

Check items that apply to blood relatives: children, sisters, brothers, parents, grandparents, aunts, uncles

YES	Condition	Relationship	YES	Condition	Relationship
	Alcohol Problem			Auto Immune	
	Drug Problem			Lupus	
	Allergy Environment			Alzheimers	
	Allergy Food			Parkinson's	
	Asthma			Inflammatory Bowel	
	Anemia			Crone's Disease	
	Arteriosclerosis			Ulcerative Colitis	
	Inflammatory Arthritis			Celiac Disease	
	Binge eating			ALS	
	Diabetes			Motor Neuron Disease	
	Epilepsy/Seizure			Genetic Disorder	
	Heart Disease			ADHD	
	Skin Disease			Autism	
	AIDS			Bipolar	
	High Blood Pressure			Eczema	
	High Cholesterol			Psoriasis	
	Kidney Disease			Syphilis	
	Liver Disease			Gonorrhea	
	Depression			Psychiatric Disorders	
	Obesity			Schizophrenia	
	Stroke			Breast Cancer	
	Suicide			Ovarian Cancer	
	Thyroid Disease			Prostrate Cancer	
	Tuberculosis			Skin Cancer	
	Ulcers			Lung Cancer	
	Multiple Sclerosis			Colon Cancer	

All Patients – Personal Birth History

☐ Term ☐ Premature ☐ Length of labor_____ ☐ Cord around neck?
☐ Breach delivery ☐ Other birth difficulties _____
☐ Pregnancy complications _____
☐ Breast fed ☐ Formula fed ☐ Trouble with solid foods ☐ Trouble with digestion

Childhood History

☐ Growth Abnormal ☐ Learning Difficulties ☐ Attention Difficulties ☐ Allergies
☐ Good Grades in school ☐ Toxic Exposure ☐ Head injuries ☐ Loss of Consciousness
☐ Falls (downstairs, off bike) ☐ Bunps to head ☐ Football/boxing/wrestling/contact sport
☐ High fevers ☐ Infections ☐ Diagnosed viral infections ☐ Anaesthesia
Diet ☐ Sugar ☐ Aspartame ☐ Gluten ☐ Dairy ☐ Saturated fats ☐ GMO's
☐ Vegetarian ☐ Eat meat ☐ Regular 3-meals per day
Family ate processed, canned, boxed foods and restaurant food often ☐ Yes ☐ No

Family used microwave cooking on regular basis ☐ Yes ☐ No
Foreign Travel as Child or Adult: Where _____
_____ **How Long?** _____

Men's History (*for men only)*
☐ Urgency/Hesitancy in Urinary Stream ☐ Urination at night Times per night? _____ ☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in libido ☐ Difficulty Obtaining or Maintaining an erection ☐ Impotence
PSA done? ☐ Yes ☐ No PSA Level ☐ 0-2 ☐ 2-4 ☐ 4+ ☐ over 10

Women's History (*for women only)*
Hormonal Imbalances and Women's Disorders
☐ Painful periods ☐ Heavy periods ☐ PMS ☐ Endometriosis ☐ Infertility
☐ Fibroids ☐ Fibrocystic breasts ☐ Menopause ☐ Age at menopause _____
☐ Hot flashes ☐ Memory/Concentration ☐ Mood swings ☐ Libido low
☐ Weight gain ☐ Headaches ☐ Joint pain
☐ Last Mammogram _____ ☐ Breast Biopsy Date _____
☐ Last PAP test _____ ☐ Normal ☐ Abnormal
☐ Date last bone density test _____ Results ☐ High ☐ Low ☐ Normal

Obstetric History ***Please check box and also provide number of***
☐ Pregnancies ____ ☐ Vaginal deliveries ____ ☐ Caesarians ____
☐ Living children ____ ☐ Miscarriages ____ ☐ Abortions _____
☐ Breast feeding ____ ☐ How long? _____
☐ Gestational diabetes ☐ Baby over 8 pounds
☐ Toxemia ☐ Post partum depression **How long?** _____

Menstrual History
Last period _____ Age at first period _____
Menses frequency _____ Length _____ Clotting ☐ Yes ☐ No
Painful menses ☐ Yes ☐ No Ever skipped? ☐ Yes ☐ No
☐ Birth Control Pill? How long? _____ ☐ Patch? How long? _____☐ Nuva Ring? How long? _____ ☐ Other Means of Birth Control? _____
General Health Overview

Complaints and Concerns
If you could magically erase three problems, what would they be?

1. _____
2. _____
3. _____

Describe the number one improvement you hope to achieve in your visits with us?
_____
_____
_____

Tell us about the last time you felt well _____
_____
_____
Did something trigger your change in health? _____
_____
_____
Tell us about what makes you feel worse _____
_____
Tell us about what makes you feel better._____
_____

Please list current problems in order of priority. Place 'x' in appropriate box.

Problem: 1=Mild 2=Moderate 3=Severe **Treatment Results: 1=Excellent 2=Good 3=Fair**

Write Problem Below	**1**	**2**	**3**	**Prior Treatment Used**	**1**	**2**	**3**
Example: Chronic Sinusitus		x		*Acupuncture*		x	

Medical History: Conditions/Diseases/Diagnoses

SURGERIES	PREVENTATIVE LAB TESTS
☐ ☐ Hysterectomy	☐ ☐ Bone Density
☐ ☐ Gall Bladder	☐ ☐ Colonoscopy
☐ ☐ Hernia	☐ ☐ EKG
☐ ☐ Appendectomy	☐ ☐ EBT Heart Scan
☐ ☐ Tonsillectomy	☐ ☐ Cardiac Stress Test
☐ ☐ Dental Surgery	☐ ☐ CT Scan
☐ ☐ Pacemaker	☐ ☐ Upper Endoscopy
☐ ☐ Angioplasty or Stent	☐ ☐ Upper GI Series
☐ ☐ Heart Bypass Valve	☐ ☐ MRI

☐ ☐ Other Heart Surgery	☐ ☐ Ultrasound
☐ ☐ Joint Replacement	☐ ☐ Hemoccult Test (blood-stool)
☐ ☐ Other Surgeries	
	BLOOD TYPE
	☐ A ☐ B ☐ AB ☐ O
	Date/Place Last Complete Physical Exam

HOSPITALIZATIONS ☐ **None**

Date	**Reason**

COMMENTS ON HOSPITALIZATIONS

_____
_____
_____
_____
_____

Medical History: Symptoms/Conditions/Diseases/Diagnoses

Key: ☐ past condition ☐ present condition

METABOLI C -- ENDOCRINE	INFLAMMATORY -- AUTOIMMUNE
☐ ☐ Allergies	☐ ☐ Autoimmune Disease
☐ ☐ Type 1 Diabetes	☐ ☐ Rheumatoid Arthritis
☐ ☐ Type 2 Diabetes	☐ ☐ Chronic Fatigue Syndrome
☐ ☐ Hypoglycemia	☐ ☐ Lupus
☐ ☐ Metabolic Syndrome	☐ ☐ Immune Deficiency Disease
☐ ☐ Hypothyroid (low thyroid)	☐ ☐ Food Allergies
☐ ☐ Hyperthyroid (overactive)	☐ ☐ Environmental Allergies
☐ ☐ Endocrine Problems	☐ ☐ Chemical Sensitivities
☐ ☐ Polycystic Ovarian Syndrome	☐ ☐ Herpes-Genital
☐ ☐ Infertility	☐ ☐ Chronic Infectious Disease

☐ ☐ Weight Gain	☐ ☐Poor Immune Function
☐ ☐Weight Loss	☐ ☐ Other
☐ ☐ Weight Fluctuations	
☐ ☐ Bulimia	GASTROINTESTINAL
☐ ☐ Anorexia	☐ ☐Irritable Bowel Syndrome
☐ ☐Binge Eating Disorder	☐ ☐Crohn's
☐ ☐ Night Eating Syndrome	☐ ☐ Pancreatitis
☐ ☐Other	☐ ☐Ulcerative Colitis
	☐ ☐Gastritis/Peptic Ulcer
CANCER	☐ ☐ Celiac Disease
☐ ☐ Breast	☐ ☐Reflux (GERD)
☐ ☐ Ovarian	☐ ☐Hepatitis/Liver Disease
☐ ☐ Prostrate	
☐ ☐ Skin	GENITAL -- URINARY
☐ ☐ Lung	☐ ☐Yeast Infections
☐ ☐ Colon	☐ ☐Kidney Stones
☐ ☐ Other	☐ ☐Gout
	☐ ☐ Interstitial Cystitis
CARDIOVASCULAR	☐ ☐Urinary Tract Infections
☐ ☐ Stroke	☐ ☐ Erectile Dysfunction
☐ ☐Elevated Cholesterol	☐ ☐Sexual Dysfunction
☐ ☐Heart Attack	☐ ☐Other
☐ ☐ Mitral Valve Prolapse	
☐ ☐Other Heart Disease	SKIN DISEASES
☐ ☐ Hypertension	☐ ☐ Eczema
☐ ☐ Arythmia	☐ ☐ Acne
☐ ☐Rheumatic Fever	☐ ☐Psoriasis
☐ ☐Other	☐ ☐Skin Cancer
	☐ ☐Other

Medical History: Symptoms/Conditions/Diseases/Diagnoses

Key: ☐ past condition ☐ present condition

RESPIRATORY	☐ ☐Iliotibial Band Contracture
☐ ☐ Chronic Sinusitis	☐ ☐Fracture or Broken Bone
☐ ☐Sleep Apnea	☐ ☐Whiplash
☐ ☐ Asthma	☐ ☐ Overuse Injuries
☐ ☐ Bronchitis	☐ ☐ Chronic Sciatic Nerve Pain
☐ ☐ Pneumonia	☐ ☐Severe Strains or Sprains
☐ ☐Tuberculosis	☐ ☐ Leg Length Difference
☐ ☐ Emphysema	☐ ☐ Frozen Shoulder
☐ ☐ Other	☐ ☐ TMJ and Jaw Problems
	☐ ☐ Posture Dysfunction

MUSCULOSKELETAL	☐ ☐ Whiplash
☐ ☐ Dislocation of Joints	☐ ☐ Paget's Disease
☐ ☐ Subluxation of Joints	☐ ☐ Frequent Muscle Spasm
☐ ☐ Degenerative Joint Disease	☐ ☐ Myofascial Trigger Points
☐ ☐ Degenerative Disk Disease	☐ ☐ Scar Tissue
☐ ☐ Herniated Disk	☐ ☐ Other
☐ ☐ Stenosis	☐ ☐ Rotator Cuff Syndrome
☐ ☐ Spondylolisthesis	
☐ ☐ Hammer Toe	PERIPHERAL NERVOUS SYSTEM
☐ ☐ Bunion	☐ ☐ Peripheral Nerve Injury
☐ ☐ Congenital Hip Dysplasia	☐ ☐ Peripheral Nerve Lesion
☐ ☐ Osteoarthritis	☐ ☐ Bell's Palsy
☐ ☐ Scoliosis	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Kyphosis	☐ ☐ Thoracic Outlet Syndrome
☐ ☐ Lordosis	☐ ☐ Piriformis Syndrome
☐ ☐ Osteoporosis	☐ ☐ Nerve Compression
☐ ☐ Osteomyelitis	
☐ ☐ Fibromyalgia	
☐ ☐ Tendonitis	
☐ ☐ Bursitis	
☐ ☐ Tennis Elbow	
☐ ☐ Runner's Knee	
☐ ☐ Chondromalacia	
☐ ☐ Compartment Syndrome	
☐ ☐ Piriformis Syndrome	
☐ ☐ Plantar Fasciitis	

Medical History: Symptoms/Conditions/Diseases/Diagnoses

Key: ☐ past condition ☐ present condition

BRAIN HEALTH	SYMPTOMS OF BRAIN PROBLEM
DIAGNOSED BRAIN PROBLEM	☐ ☐ Sensitivity to Light or Sound
☐ ☐ Migraine	☐ ☐ Immune System Challenge
☐ ☐ Depression	☐ ☐ Muscle Spasticity
☐ ☐ Anxiety	☐ ☐ Blank Staring or Daydreaming
☐ ☐ Bipolar Disorder	☐ ☐ Marijuana or Other Drug Use
☐ ☐ Epilepsy	☐ ☐ Alcohol or Substance Abuse
☐ ☐ ADHD/ADD	☐ ☐ Memory/Learning Problems
☐ ☐ Addictive Personality	☐ ☐ Reasoning or Logic Difficulties
☐ ☐ Stroke	☐ ☐ Speech Problems
☐ ☐ Autism	☐ ☐ Problems with Concentration
☐ ☐ Parkinson's Disease	☐ ☐ Trouble Initiating Plans/Goals

☐ ☐ Chronic Tinnitus	☐ ☐ Difficulty Finding Words
☐ ☐ Asperger Syndrome	☐ ☐ Confusion
☐ ☐ Seizures	☐ ☐ Rage or Aggression
☐ ☐ Dementia/Alzheimers	☐ ☐ Behavior Disorder
☐ ☐ Dyslexia	☐ ☐ Poor Social Judgment
	☐ ☐ Emotional Instability
SIGNS OF BRAIN DYSFUNCTION	☐ ☐ Irritability or Agitation
☐ ☐ Open or Closed Head Injury	☐ ☐ Mood Swings
☐ ☐ Blow to Head from Sports	☐ ☐ History of Fevers
☐ ☐ Hit Head by Falling	☐ ☐ Sleepiness Daytime
☐ ☐ Hit on Head by Object	☐ ☐ Insomnia
☐ ☐ Whiplash	☐ ☐ Dizziness
☐ ☐ Concussion	
☐ ☐ Loss of Consciousness	
☐ ☐ Coma	
☐ ☐ Physical Assault/Violence	
☐ ☐ Physical Abuse/Fight	
☐ ☐ Choking or Suffocation	
☐ ☐ Near Drowning	
☐ ☐ Overcome: Carbon Monoxide	
☐ ☐ Overcome by Other Gas	
☐ ☐ Electric Shock Severe	
☐ ☐ Hit by Lightning	

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date	Reason for Use

PREVIOUS MEDICATIONS USED 12 MONTHS OR LONGER

Medication	Dose	Frequency	Start Date	Reason for Use

NUTRITIONAL SUPPLEMENTS

Supplement and Brand	Dose	Frequency	Start Date	Reason for Use

Antibiotics: ☐ Frequent use ☐ Long-term use
Steroids (prednisone, nasal allergy inhaler, etc) ☐ Frequent use ☐ Long-term
Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc) ☐ Frequent use ☐ Long-term
NSAIDS (Advil, Aleve, etc) ☐ Frequent use ☐ Long-term

Food/Diet and Nutrition History
Describe any changes you have made in eating habits due to health issues _____

Describe any current special nutritional program or diet? _____

Do you read food labels? ☐ Yes ☐ No
Check all that apply:
☐ Vegetarian ☐ Vegan ☐ Gluten Restricted ☐ Low Sodium ☐ Low fat ☐ High Protein ☐ Low Carbohydrate ☐ No Dairy ☐ No Wheat ☐ No Sugar ☐ Diabetic

Have you had a nutrition consultation? When _____ With Whom _____
Name of current weight loss program _____
Have you had tests for metabolism (resting metabolic rate) ☐ No ☐ Yes When _____
What foods do you avoid _____
Food Allergies _____
Foods you eat most often _____
Food cravings _____
How many balanced meals do you cook per week? _____
How many meals do you eat out per week? _____

Check all the facts that apply to your current eating habits

☐ Fast eater
☐ Erratic eater
☐ Late night eating
☐ Dislike fruits & veggies
☐ Poor snack choices
☐ Time constraints
☐ Rely on convenience foods
☐ Travel frequently
☐ Do not plan meals
☐ Eat same way as family of origin
☐ Eat because I have to
☐ Eat too much under stress
☐ Eat too little under stress
☐ General over eater
☐ Don't care to cook
☐ Struggle with eating issues
☐ Fast food often
☐ Confused about nutrition advice
☐ Emotional eater
☐ Eat the same foods over and over
☐ Have negative relationship to food
☐ Eating is a great pleasure to me
☐ Significant other doesn't like healthy food

Sleep and Rest

Average number of hours you sleep per night ☐ 4 ☐ 6 ☐ 8 ☐ 10
Do you have trouble falling asleep? ☐ Yes ☐ No – Trouble Staying Asleep? ☐ Yes ☐ No
Do you feel rested upon awakening? ☐ Very ☐ Mostly ☐ Sometimes ☐ Rarely
Do you need caffeine or stimulants to maintain energy later in the day? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No -- Sleep Apnea? ☐ Yes ☐ No ☐ Don't know

Use of Substances that Alter Metabolism or Neurotransmitters

Substance	**Times per day**	**Times per week**	**Number ounces**	**Substance**	**Times per day**	**Times per week**	**Number ounces**
Coffee regular				Alcohol			
Decaf				Marijuana/Cannabis			
Black tea				Amphetamines			
Green tea				Cocaine			
Cola, Mountain Dew				Ecstasy			
Diet Soda				LSD			
Cigarettes				Heroine			
Cigars				Opium			
Second Hand Smoke				Ketamine			

I have previously attempted to decrease use of

☐ caffeine ☐ Success ☐ No success
☐ nicotein ☐ Success ☐ No success
☐ alcohol ☐ Success ☐ No success
☐ marijuana ☐ Success ☐ No success
☐ recreational drugs list below
_____☐ Success ☐ No success

Stress and Coping

Please list in order the factors that stress you the most by writing in **1,2,3,4,5, etc.**

___Family ___Work ___ Money ___ Time for Myself ___Poor Health ___Recreation
___Time for Friends ___ Confused about Spirituality ___ Few Vacations ___Lack Sleep
___ Taking care of parents or handicapped person ___Boredom ___Poor Lifestyle Habits

Overall how high is the stress in your current life? ☐ Low ☐ Moderate ☐ High
Overall how well do you handle stress in your life? ☐ Well ☐ Could be better ☐ Poor
How do you handle stress: ☐ Meditation ☐ Breathing ☐ Yoga ☐ Tai Chi ☐ Prayer
☐Awareness of Thought ☐ 12-Step Program ☐ Centering ☐ Releasing ☐ Forgiving
☐Other means of handing stress _____
Have you been abused, a victim of crime, or experienced major trauma? ☐ Yes ☐ No
Are you currently in therapy? ☐ Yes ☐ No

How many persons live in your household? ___ How many generations in home? ___
Number children living in household: ___ Ages_____

General Psychosocial

How happy are you? ☐ Very ☐ Mostly ☐ Sometimes ☐ Rarely
Is life meaningful and purposeful for you? ☐ Very ☐ Mostly ☐ Sometimes ☐ Rarely
Do you enjoy the work that you do? ☐ Very ☐ Mostly ☐ Sometimes ☐ Rarely
How safe and secure do you feel? ☐ Very ☐ Mostly ☐ Sometimes ☐ Not at all
Is your current home/family life happy? ☐ Very ☐ Mostly ☐ Sometimes ☐ Rarely
Do you spend time with supportive friends? ☐ Very ☐ Mostly ☐ Sometimes ☐ Rarely
Briefly describe the two biggest losses in your life

_____
_____

READINESS & PREPARATION FOR HEALTHY CHANGE & WELLNESS	**VERY READY**	**READY**	**NOT READY**	**NOT SURE**
My spouse is supportive of my health				
I have two friends to encourage me				
My children support my health goals				
I have a role model for success				
I have a Life or Wellness Coach				
I have money saved for my therapies				
I am able to pay out-of-pocket preventative health costs				
I can make time for learning new skills				
I can make time for cooking				
I can make time for regular healthy exercise				
I can make time for fun and pleasure				
I am willing to set new priorities				
I am willing to journal about my progress				
I want to pay closer attention to myself				
I have reasonable expectations				
I understand it takes months to improve health & habits				
I am willing to deepen my spiritual practice				
I am willing to read new books and articles				
I am willing to take seminars				
I am willing to modify my diet				
I am willing to take nutritional supplements				
I am willing to eliminate toxic substances from my life				
I am willing to sleep more hours				
I am willing to limit caffeine				
I am willing to limit alcohol				
I am willing to stop smoking				
I am willing to practice a relaxation technique daily				
I am willing to have lab tests to assess my progress				
I am confident that I will follow-through and persist				
I expect to enjoy the process of healing				
I will make short-term sacrifices to improve my health				

How much support and contact do you want from our staff? (phone calls, email)

_____

Is anyone in your household oppositional or discouraging?

_____

Will other household members make positive changes with you (especially in diet)?

_____

What is the one thing that might hold you back?

_____

QUALITY OF LIFE ASSESSMENT	MOST OF THE TIME	SOME OF THE TIME	RARELY IF EVER
I feel energetic and full of life			
I feel calm and peaceful			
I am happy most of the time			
I love myself and others			
I expect to live a long life			
I look forward to work			
I enjoy my spouse and family			
I enjoy sex and intimacy			
I am able to let-go and trust others and the Divine			
I take personal responsibility for the quality of my life			
I practice self-love along with love/support for others			
I practice mindfulness or heartfulness			
It is easy for me to choose options and make changes			
Motivation planning & completion of tasks is satisfactory			
I forgive easily			
I practice respectful and gentle communication			
I can do vigorous activities like running & dancing			
I can do moderate activities like walking & golf			
I can kneel/ bend/ stoop and climb easily			
I let other people interfere with my personal plans			
My emotional problems interfere with my success			
I grumble and complain			
I tend to blame others when things don't go well			
I feel overly responsible for other people & situations			
I am a nervous person			
I seem to get sick easier than other people			
I often accomplish less than I hope to			
My mental health is declining			
My physical health is declining			
I have trouble trusting others			
I feel downhearted and blue			
I resent all the responsibilities I carry			
Others expect too much of me			
I expect too much of myself			
Sometimes I think about ending my life			
My health interferes with social life			
My health interferes with family life			
My health interferes with my work			

Thank you for completing this general health inventory!
We recommend that you also take the Toxicity Inventory to determine your exposure, risk and status with regard to environmental toxins.