

NAME _____
DATE _____

Welcome to UR Wellness!
Health Care Inventory

Please take the time to document your Health Care History. This intake form is designed to collect important information about your health and to allow you to reflect on your health history both past and present.

Your Vital Information

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal: _____

In case of an emergency Please notify _____

Home Phone: (____) _____

Business Phone: (____) _____

Cell Phone: (____) _____

Email: _____ Occupation: _____

Date of Birth: ____ / ____ / ____
 month day year

Marital Status: Married _____ Single _____ Widowed _____ Divorced _____

Name of Spouse/Partner: _____

Do you have children? Circle one: No Yes # of children _____

Do you have children living at home? Circle one: Yes No

What services are you seeking at UR Wellness?

Example: neurofeedback/reflexology/craniosacral therapy/combination approach?

How did you hear about UR Wellness?

Is there anything about your Health we should know about?

What is your level of commitment to yourself, your life and wellbeing?

Please Circle One; High Medium Low

Have you experienced Neurofeedback, Reflexology or Craniosacral Therapy before, and if so, what was your experience?

Your Life Style History

Everything we have done in the past contributes to who we are today. Our goal is to help you release deep limiting belief systems and the more we know about you, the more we can help you with your healing process.

What brings you into our centre today?

When did you first notice it and what do you attribute it to?

What goals are you looking to achieve through our services?

Medications (including vitamins, prescription or otherwise):

Current health care providers?

Chiropractor _____

Massage Therapist _____

Naturopath _____

Counsellor _____

Acupuncturist _____

Other _____

Developmental History-

Please fill out as much information as you can. Sometimes the information is not known. If the information is available, it can be very enlightening to research the answers!

Please indicate your history in relation to the following:

Are you adopted? No Yes If so at what age? _____

Prenatal Birth: Indicate if your birth experience included:

Prenatal Stress or Injury	_____	Birth Trauma	_____
Prenatal Drug/alcohol exposure	_____	Pre-mature	_____
Anaesthesia/pain medication	_____	Lack of oxygen	_____
Medical problems after birth	_____	Unknown	_____

Growth & Development: Please indicate if Typical (T); More (M) or Less (L)

Activity Level	_____
Motor coordination	_____
Infections/allergies	_____
Emotional Development	_____
Behavioural concerns	_____
Ability to fall asleep	_____
Language/speech development	_____
Appetite/Digestion	_____

History of Physical Stress, Trauma or Challenges: Do you have any history of:

- Head injury (even minor falls) _____
- Car Accident(s) _____
- Coma _____
- High Fevers _____
- Serious Illness _____
- Surgery _____
- Stroke _____
- Recreational Drug Use _____
- Other: please explain _____

Psychological Stress/Life Style Changes:

Our expression of health, healing and life is greatly influenced by our emotional well-being. Have you been through a difficult divorce/break-up, stressful job, school, family life, etc...? Indicate if you have experienced:

- Death in Family _____
- Divorce/remarriage _____
- Move/relocation _____
- School Change _____
- Job Change _____
- Other _____

Pregnancy/Birthing Experience:

A typical unnatural birth is usually traumatic for both the mother, child and father. A mother's experience during pregnancy and birth can have an impact, both physically and emotionally. If you have children, what was your experience and how was your child/children brought into this world?

Tell us about your food intake/nutrition:

Do you eat junk food, skip meals, diet, etc..? Are you a vegetarian, vegan, raw, macro, whole foods, meat eater? Do you use supplements? What are your nutritional goals?

Fluid intake:

What do you drink? (alcohol, water, coffee, tea, cow's milk, soft drinks, diet soft drinks, etc...) and how often?

History of Chemical Stress, Trauma or Challenges:

Are you challenged with allergies, asthma, food allergies, chemical sensitivities, chemical addictions (alcohol or drug), previous overdose or poisoning, etc...?

Please explain: _____

Alcohol use (how much?) _____

Caffeine use (how much?) _____

Tobacco use (how much?) _____

Previous Tobacco use? How much? _____ How long? _____

Sleep & Rest:

Quality of sleep/Amount of sleep or rest – need more or less?

Exercise:

Exercise is a vital part of life. Exercise causes an increase in energy in our bodies. What kind of exercise do you do and how often? Are you happy with your current level of exercise?

Family relationships:

How are your family relationships and how do you feel after having contact with your family? (Energized, fulfilled, content, frustrated, exhausted)?

Type of work:

What do you do for a living? Who do you work for?

Level of satisfaction with career:

Why do you, do what you do? What do you get out of it?

Vacation:

Do you allow yourself a vacation? How often and when was your last one?

Play & relaxation:

What do you do to revitalize, re-energize and/or reconnect yourself?

Financial Health:

Do you have any financial stressors? And if so, how do you think they are contributing to your current health and lifestyle?

Current Symptom Check List: please check all that apply

	✓ Client	✓ Family	✓ Current
Always on the go	_____	_____	_____
Unable to relax	_____	_____	_____
Feeling tense	_____	_____	_____
Depressed	_____	_____	_____
School problems	_____	_____	_____
Hyperactivity	_____	_____	_____
Attention problems	_____	_____	_____
Memory problems	_____	_____	_____
Behavioural problems	_____	_____	_____
Difficulty making friends	_____	_____	_____
Vocal or motor tics	_____	_____	_____
Sleep problems	_____	_____	_____
Nightmares	_____	_____	_____
Frequent Illnesses	_____	_____	_____
Shy with people	_____	_____	_____
Oppositional	_____	_____	_____
Headaches	_____	_____	_____
Allergies	_____	_____	_____
Physical/Sexual Abuse	_____	_____	_____

Seizures	_____	_____	_____
Food Sensitivities	_____	_____	_____
Head injury	_____	_____	_____
Temper tantrums	_____	_____	_____
Remorseful after tantrums'	_____	_____	_____
Bedwetting	_____	_____	_____
Teeth grinding	_____	_____	_____
Rages	_____	_____	_____
Verbal aggression	_____	_____	_____
Inferiority feelings	_____	_____	_____
Cannot make decisions	_____	_____	_____
Unmotivated	_____	_____	_____
Lack of energy	_____	_____	_____
Frequent stomach aches	_____	_____	_____
Poor math concepts	_____	_____	_____
Poor spelling concepts	_____	_____	_____
Poor language skills	_____	_____	_____
Rush through work	_____	_____	_____
Poor visual tracking	_____	_____	_____
Perfectionist	_____	_____	_____
Poor eye contact	_____	_____	_____
Loud un-modulated voice	_____	_____	_____
Generalized anxiety	_____	_____	_____
Misses social cues	_____	_____	_____
Manipulative	_____	_____	_____
Fearful	_____	_____	_____
Lack empathy	_____	_____	_____
Difficulty meditating	_____	_____	_____
Tremors	_____	_____	_____
Chronic Pain	_____	_____	_____
Fibromyalgia symptoms	_____	_____	_____
Heart Palpitations	_____	_____	_____
High Blood Pressure	_____	_____	_____
Addictions	_____	_____	_____
Compulsive overating	_____	_____	_____
Binging and purging	_____	_____	_____
Repetitive Behaviours/rituals	_____	_____	_____
Stubborn	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

Is there anything else you would like us to know? Any insights to limiting belief systems etc?

Philosophical Agreement

UR Wellness exists to make a positive contribution in the lives of people, by assisting them to express and experience more balance in their lives. Our services are not a substitute, an alternative or a preventative form of medicine. It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional ailments, or to give advice about medical conditions. If, while in our care, you become concerned about symptoms or conditions, we suggest you discuss this with us and we will assist you to seek the help of a professional health care practitioner. Our services can elicit the relaxation response which has been documented to reduce physical & emotional stress. People who engaged in our services have reported a reduction of physical and emotional symptoms which can cause you to communicate better with yourself and the outside world. Our primary goal is to assist you to bring balance into your life by assisting you to increase your body awareness, by making healthy lifestyle choices and learning stress management strategies.

To gain maximum benefit from your sessions with Penny Hyndman, it is recommended that you follow the following recommendations:

#1 Consistency in Visits-On your first visit, we will discuss frequency and number of sessions to reach maximum progress. We ask that you make a commitment to the health plan by making your visits a top priority. Our services work best with consistent and cumulative care. Your time is reserved for you and missed appointments will be billed for.

#2 Eat an organic whole foods diet-This is one of the most important steps you can take to heal all kinds of chronic issues. Keep yourself hydrated with fresh water.

#3 Exercise 3-4 times per week-Walking, stretching, yoga, biking, etc. Preferably you can find something you enjoy.

#4 Take a few minutes a day of quiet time and introspection-meditation is ideal for this purpose.

#5 Be willing to let go of addictions that are undermining your health

#6 Avoid Sugar and Stimulants -Immediately prior to your visits. This will maximize the benefits.

We have found that our services can work on very profound levels if these basic steps are taken. We only ask that you do the best you can to follow these guidelines, as they will ensure that you receive the full benefit from our care.

I _____ the undersigned, have completely read and understand the above statements.

☞ Signed: _____ Dated: _____

☞ Witness: _____ Dated: _____

