

THE HEALING ATELIER

THIS PACKET CONTAINS TWO SECTIONS:

- 1. CONFIDENTIAL PATIENT INFORMATION FORM**
- 2. CONFIDENTIAL GENERAL HEALTH QUESTIONNAIRE**
- 3. LIFESTYLE AND RISK ASSESSMENT EVALUATION**

Please print out and bring these completed forms with you to your first visit. Completing these forms is an educational process also. Please take your time and answer comprehensively. We look forward to providing you with considered, comprehensive, alternative care. Thank you for the opportunity to serve you!

1. Confidential Patient Information

Date: _____
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: () _____ Work Phone:() _____
Cell Phone: () _____

Name of Parent/Guardian (if minor): _____
Parent's Address: _____

Emergency Contact: _____ Phone:() _____

How did you hear about The Healing Atelier?

- Internet Search – Which site or search engine?
- Referred by a friend or acquaintance:
- Referred by another health care practitioner:
- Other?

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2. Confidential General Health Questionnaire

Please take time to fill out this questionnaire carefully. We appreciate your time and effort. If you have concerns that are not listed, please include them. The completed form will assist us in understanding you and help us to provide you with highly personalized, specific health and lifestyle recommendations and services.

Name: _____

Do you consider yourself: Please ✓ before that which applies to you:

generally healthy? in average health? in poor health? sickly? prone to infections?
robust? currently symptom free? recently improved? over-weight? under weight?

Gender: M / F Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Ideal Weight: _____

Circle One: Minor Single Married Partnered Divorced Widowed

Number of children: _____ Ages? _____ Do you live with them? Y/N

Do you have in indoor pet or pets? Y/N What kind? _____

Profession: _____

Date of last physical exam: _____ Date of last blood work? _____

Have you traveled outside the US? Y/N Where: _____

Blood Type: _____ Cholesterol Level: _____ Blood Pressure: _____

Complaints: Please list in order of importance your health concerns.

1. _____
5. _____
2. _____
6. _____
3. _____
7. _____
4. _____
8. _____

Medications: Please list all pharmaceutical medication(s) that you are currently taking, dosage, frequency and indicate how long you have been taking the medication. (include birth control, aspirin, pain meds, etc..)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Are you allergic to any medications? Y/N If "Yes", which ones: _____

What happens when you have an allergy attack to medication?

Surgeries, Operations: Please include plastic surgery, breast implants, elective surgeries, mole and wisdom teeth removal, etc.. explain reason, year and duration:

1. _____
2. _____
3. _____
4. _____

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5. _____
6. _____
7. _____
8. _____
9. _____

Traumas: Please list all car accidents, falls, lacerations, bone fractures and serious bruising, exceptional emotional traumas, or unusual scarring events:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Scars: Please list all your scars and their approximate location including vaccination marks, warts, liposuction marks, hidden face-lift scars, etc...

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Supplements: Please include all homeopathics, herbs, vitamins, minerals you are currently taking, include dosage.

1. _____
5. _____
2. _____
6. _____
3. _____
7. _____
4. _____
8. _____

Stress: Please rate your stress level on a scale of 1 to 10 with ten being the highest. _____

What are the main reasons for stress in your life: _____

What do you do to manage your stress: _____

Health Habits Assessment

Do you smoke tobacco currently or in the past? Y/N When? _____

Do you currently drink alcohol? Y/N 4oz.glasses wine/week? _____ beer? _____ hard liquor _____

Have you ever abused alcohol? Y/N Have you ever abused recreational drugs? Y/N When/How Long? _____

Have you ever become addicted or abuse(d) pharmaceutical medications? Y/N Which ones: _____

Do you exercise? Y/N Circle: 1x 2x 3x 4x 5x 6x 7x/week What kind of exercise? _____

Have you always exercised? Y/N When did you start exercising? _____

Average hours sleep per night: _____ Do you wake up in the middle of the night? Y/N How many

times? _____ What time do you usually go to bed? _____ Other: restless restful get up during night bad

dreams Other sleep complaints? _____

Do you follow any dietary modifications / restrictions? Y/N Please describe:

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Food or Environmental Allergies: *List any known allergens here.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PRELIMINARY ENVIRONMENTAL EXPOSURE ASSESSMENT: *Please place a check ✓ before the question if it applies to you. Please provide details as necessary (ie., approximate dates, frequency and duration of exposure times, and indicate if you have continued exposure).*

Have you ever worked around known toxic chemicals?

Have you ever been exposed to chemical solvents?

Do you have a hobby that exposes you to chemicals? What hobby? _____

Do you exercise outside at peak traffic hours?

Do you use oil paints?

Do you have mercury amalgam fillings? How many? _____ For how long? _____

Have you ever been excessively exposed to toxic fumes?

Is there any known exposure to any heavy metals?

Are you a gardener?

Do you eat fish or shellfish? Y/N How often/week?

Do you have difficulty sleeping if you consume caffeine in the afternoon?

Are you overly sensitive to alcohol?

Are you sensitive to any chemicals?

Do you react easily to pharmaceutical medications?

How many hours/day at the computer? _____

How many hours/day on a cell phone? _____

How many hours/day watching TV? _____

Your Past Medical History: *Please circle appropriately as it applies to you.*

Allergies ADD/ADHD Alcoholism Anemia Anorexia/ Bulimia Anxiety/Depression Arthritis
Allergies/Hives Autoimmune Disease Asthma Bleeding Disorder Blood Lipid Disorders Gout
Neuralgias Blurred Vision Cardiac Conditions Bloody Stools Candida (Yeast) Dizziness/Vertigo
Chemical Sensitivity Chronic Fatigue Colitis Diabetes Eczema Rashes Hives
Emphysema Fainting Fibromyalgia Genital Herpes Gastrointestinal Disorders Ulcers
Glaucoma GERD Seizures Neuritis Thyroid Disorder Cysts Depression/Suicide Tuberculosis
Kidney Disease Pneumonia Schizophrenia Obesity Tumors Migraines Gangrene Hemorrhoids
Heart Attack High Blood Pressure Mental Illness Obesity Parkinson's Disease Prostate Conditions
Lupus ALS Multiple Sclerosis Diabetes Epilepsy Colitis Glaucoma AIDS/HIV Cancer: Type?
Fibromyalgia Other Heart Condition Macular Degeneration

Other: _____

Family Medical History

Please indicate age if living or age at death and cause of death. Also indicate any current and past diseases and conditions. Please refer to the above list as necessary.

Mother

Father

Sibling

Sibling

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Sibling

Sibling

Sibling

Maternal Grandmother

Maternal Grandfather

Paternal Grandmother

Paternal Grandfather

Your Current Symptoms and Complaints:

Please place a check ✓ before the symptom then give details (ie., where, how often, how intense, since when? etc...) and explain further as necessary.

For example: ✓ Feel tired or worn out? can barely get out of bed, better once I move around

GENERAL SYMPTOMS:

Feel tired or worn out?

Low blood sugar?

Increased thirst?

Indigestion?

Depression?

Weight gain / loss recently?

Perspire a lot?

Heat intolerance?

Cold intolerance?

Medical diagnosis: _____

SKIN / HAIR / NAILS:

Changes in the color of your skin?

Skin rashes, itching, hives, or eczema?

Unusually dry skin?

Growths on your skin?

Sores or wounds that do not seem to heal?

Moles? Warts?

Fatty deposits?

Colored streaks/stretch marks?

Skin discolorations

Peeling, cracking, or weakness of your fingernails?

Discoloration of your fingernails or toenails?

Irregular hair loss or growth?

Bulging veins?

Medical diagnosis: _____

EYES:

Eye pain?

Blurred vision?

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Dry eyes?
Floaters?
Sensitive to light?
Pressure in eyes?
Temporary blindness?
Foggy patches?
Nearsighted or Farsighted? (circle one)
Changes in your vision?
Eye itching or watering?
Redness or burning?
Halos around lights?
Medical diagnosis: _____

EARS / NOSE / THROAT:

Difficulty hearing?
Ear infections?
Buzzing or ringing in your ears?
Hearing as if through a fog horn?
Earaches or discharge from your ears?
Nasal stuffiness or sinusitis?
Popping?
Post-nasal drip or frequent desire to clear the throat?
Frequent or severe nose bleeds?
Difficulty swallowing or choking on food?
Constriction in the throat?
Soreness of the tongue or mouth?
Chancre sores?
Excess saliva or drooling?
Dry mouth?
Bad breath?
Nasal congestion?
Medical diagnosis: _____

RESPIRATORY:

Frequent chest colds?
Constant or bothersome cough?
Coughing up blood?
Difficulty breathing?
Wheezing or whistling on inhaling or exhaling?
Shortness of breath?
Shortness of breath with exercise?
Sleep apnea?
Allergies?
Medical diagnosis: _____

CARDIOVASCULAR:

High blood pressure?
Pain, tightness, or pressure in front or back of your chest?
If yes, is it when walking fast, working hard, or when excited?
Have you ever had a abnormal EKG?
Swelling of your feet and ankles?
Cramps in the calf muscles when you walk?
Awaken at night with difficulty breathing or suffocation?
Need to sleep on more than one pillow?

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Bruise easily?
Varicose or spider veins?
Hear your heart pounding?
Fast or irregular heartbeat such as palpitations?
Do your fingers or toes ever get cold, become numb, or turn bluish?
Low blood pressure?
Dizziness upon getting up?
Medical diagnosis: _____

GASTROINTESTINAL:

Changes in your eating habits?
Are there any foods that upset your stomach or cause burning or pain?
Frequently experience nausea or vomiting?
Excessive gas, bloating, belching or flatulence?
Ever vomited blood?
Frequent indigestion, heartburn, or reflux?
Acid reflux?
Do you burp often?
Frequent constipation?
Frequent diarrhea?
Alternating diarrhea / constipation?
Unidentified pain in gut?
Poor appetite or easily satiated?
Blood in the stools?
Hemorrhoids?
Frequent use of laxatives?
Bloating or fatigue after meals?
Abdominal pain or cramping?
How many bowel eliminations/day? _____ Consistency: hard formed soft watery
variable
Stool color: pale brown, yellowish, med. brown, black, whitish Estimate amount per
day _____
Other: scanty too little incomplete must bear down explosive complete offensive
odor
Medical diagnosis: _____

GENITOURINARY:

What color is your urine usually?
Burning or pain on urination?
Urinary frequency or urgency?
Urinary incontinence?
Do you have to wake frequently at night to urinate?
Frequent bladder or kidney infections?
Men, any prostate trouble?
Testicle swelling or shrinking?
Men, any erectile dysfunction?
Men, fatty breasts?
Dribbling urine?
Strong smelling urine?
Frequent yeast infections or "jock itch"?
Medical diagnosis: _____

MUSCULOSKELETAL:

Frequent or chronic back pain?

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Neck pain?
Wrist pain?
Pain in the legs or feet?
Scoliosis?
Morning achiness?
Joint pain or stiffness?
Swollen joints? Which?
Trouble walking or weakness?
Easily fatigued with exercise?
Do you experience pain regularly your body? Where?
Do you experience general body pain?

NERVOUS SYSTEM:

Frequent or severe headaches?
Dizzy spells, fainting, or lightheadedness?
Loss of concentration?
Loss of orientation?
Migraines?
Tingling in limbs?
Numbness?
Shooting pains?
Shingles?
Have you ever lost the ability to speak?
Have you ever lost consciousness?
Seizures or convulsions?
Insomnia?
Head trauma?
Medical diagnosis: _____

PSYCHOLOGICAL / MENTAL/ EMOTIONAL

Nervousness?
Anxiety or panic attacks?
Sadness or depression?
Poor memory?
Moodiness, irritability, or anger?
Restlessness?
Hospitalized for a psychological condition?
Have you ever attempted suicide?
Suicidal thoughts?
Medical diagnosis: _____

WOMEN ONLY - GYNECOLOGY & PREGNANCY:

Please specify the number of: Births _____ Miscarriages _____ Abortions _____ Age at first
period: _____ Age at menopause: _____ Menopausal symptoms: _____
Regular or Irregular cycles? (circle one) Duration of flow: _____ Days between cycles : _____
Flow (✓one): Excessive Moderate Scanty
PMS (✓one): Severe Moderate Mild Never
Symptoms: _____
Date of last period: _____ Method of birth control: _____

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Gynecological History: *Please ✓ before those that apply:*

Breast lumps Vaginal discharge Vaginal dryness Infertility issues IUD Hysterectomy
Breast tenderness Nipple discharge Vaginal itching Abnormal PAP History of genital warts
Painful intercourse Water retention Spotting between periods Mother/Sister breast cancer
Breast fed Irregular periods Currently breastfeeding Profuse or Dark flow Uterine Fibroids
Ovarian tumor Currently taking The Pill Currently pregnant

Health Goals

Have you any specific health goals? Y/N *Please list your health goals on the lines below.*

Do you have a specific goal for the initial visit? Y/N What is it?

Other:

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3. LIFESTYLE AND RISK ASSESSMENT EVALUATION

Please complete the following questions carefully. With this information we will be better able to build a personalized nutrition and healthy living lifestyle program for you.

Date:

Name: _____

Sunlight

How much time do you spend outside daily? _____

How many hours under fluorescent lights? _____

What type of light bulbs do you use in your home? _____

Amount of sunlight you receive daily through windows? _____

Do you wear sunglasses outside? Y/N always usually sometimes rarely never

Eyewear

Do you wear contact lenses? Y/N If so, what type? _____ How many hours/day? _____

Have you had Lasik surgery? Y/N When? _____

Do you wear glasses? Y/N How many hours/day? _____

Tinted Lenses? Y/N Anti-glare coating? Y/N Scratch-resistant coating? Y/N

Clothing

How often do you wear clothing made of 100% natural fibers (ramie, cotton, silk, wool, linen)?

always usually sometimes rarely never

How often do you wear clothing made of synthetics (polyester, acrylic, nylon, rayon, etc...)?

always usually sometimes rarely never

How often do you wear clothes of blended natural and synthetic fibers?

always usually sometimes rarely never

Electrical Devices, Cookware and Appliances

Is your stove gas or electric? _____

What type of cookware do you use? stainless steel enamel aluminum iron teflon-coated non-stick glass Ultrex copper Other: _____

Do you use a shower filter? Y/N

Do you use an air purifier? Y/N

Electromagnetic Exposure

Do you have a pacemaker? Y/N Since when? _____

Do you wear a battery operated watch? Y/N How many hours/day? _____

Do you use an electric toothbrush? Y/N

Do you wear a hearing aid? Y/N Which ear(s)? _____ Since when? _____

Do you wear a cell phone on your person? Y/N How many hours/day? _____ Where? _____

How many hours per day are you on the phone? _____ on a cell phone? _____

What type of cell phone do you have? _____

For how many years have you been using a cell phone? _____

Do you wear a pager? Y/N How often? _____ How many hours/day? _____

How many hours watching TV per day? _____

Do you wear any other electrically powered devices on or in your body? Y/N *Please explain:*

Do you live or work within 1/2 mile of a cell phone tower? Y/N

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Is your bedroom within 100 feet or less of a power transformer on a telephone pole? Y/N

Is there an electric (plug-in) clock within 4 feet of your head when you sleep? Y/N

Do you have a television or other major electrical device in your bedroom? Y/N

Do you sleep with a whole house alarm system on? Y/N

Do you keep your cell phone by your bed and on all night? Y/N

Sleep Habits and Bedroom Considerations

Do you go to bed at the same time most nights? Y/N When is that? _____

Do you snack before bed? Y/N

Do you keep a light on at night? Y/N

How well do you sleep? soundly moderately deep lightly very lightly

How many times a night do you wake up? _____ How many times/week? _____

At what time of night do you usually wake up? _____

Does your pet sleep on your bed? Y/N NA

When do you wake up in the morning? _____

Do you feel refreshed in the morning? Y/N

What direction does the top of your head point when you sleep? north south east west

What type of sheets and blankets do you use? 100% cotton poly-blends silk polyester wool

Are the sheets permanent pressed? Y/N

What type of pillow do you use? _____

What type of bed do you sleep on? box spring water bed air mattress foam mattress synthetic latex cotton futon

Is your room in complete darkness when you sleep? Y/N

Do you have an electric clock or radio by your bed? Y/N

Do you sleep with the windows open? Y/N Does your bedroom window get morning sun? Y/N

Do you have a computer or television in your bedroom? Y/N

Do you recharge your cell phone by your bed? Y/N Is it kept on all night? Y/N

Personal Care Products: *Please indicate which brand product as applies to you.*

How often do you wear make-up? everyday every other day sometimes on occasion never

How often do you use nail polish? everyday every other day sometimes on occasion never

Have you had toxic chemicals poured on you? Y/N What chemical? _____

	Brand name		Brand name
Shampoo		Shave Cream	
Deodorant		Dish Detergent	
Toothpaste		Laundry Soap	
Bath Soap		Tub/Tile Cleaner	
Moisturizers		Glass Cleaner	
Hair Spray/Gel		Perfume/Cologne	
Per. Lubricant		Ant/Insect Spray	
Contraceptive		Toilet Cleaner	

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	Brand name		Brand name
Hair Dye		Hair Perm	
Dryer Sheets		Facial Make-up	

Food Choices and Eating Habits

Where do you do most of your food shopping? _____
 How many times/week do you eat out? _____ What type of food do you eat at restaurants? _____

Do you eat breakfast? Y/N

Do you (*please circle*) eat regularly eat irregularly skip meals eat mostly at night

Do you prepare your meals at home? Y/N How many times/week? _____

Do you eat foods and drink drinks that list 'natural flavors'? Y/N

Do you eat foods with MSG? Y/N

Do eat foods with aspartame and other chemical sweeteners? Y/N

Do you purchase organic food? Y/N

Do you buy direct from an organic farmer? Y/N

What percentage of the food you is eat is organic? _____

Do you eat naturally raised meat and animal products? Y/N

Do you eat naturally raised animal products (ie., milk, cheeses, eggs)? Y/N

What type of oil do you eat? _____

How often do you eat salads in the winter? _____/week

Please complete the following table. Do your best to answer accurately and honestly.

Food	How often/week	What type?	Brand Name
red meat			
fowl (chicken, turkey, etc...)			
fish			
fresh vegetables			
fresh fruit			
milk			
cheeses (cottage, etc..)			
ice/sour cream			
butter			
yogurt			
eggs			

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Food	How often/week	What type?	Brand Name
oils			
mayonnaise/margarine			
pre-packaged food			
frozen food/dnners			
chips- corn, potato, pretzels			
fried foods			
take-out food			
fast food			
microwaved food			
condiments (ketchup, pickles, etc...)			
sodas/pop			
drinks w artificial flavors, sweeteners			
coffee			
black tea			
alcohol			
deserts, pastries, cookies			
chocolate			
candies, candy bars, sweets			
raw nuts			
nut butters			
roasted nuts			
pasta			

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Dinner: (Time eaten_____)

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Office Policies

Scheduling Appointments

Consultations are by appointment only. Weekend and evening appointments are available for your convenience. To optimize consultation time, we ask that you bring a completed first visit packet to your first appointment. To arrange a consultation, please call 408.499.6291.

Payment

Full payment for consultations services and products is required at the time of service. We accept payment by cash, check or credit card (Visa, Mastercard). Payment plans are available in cases of financial hardship. Checks or charges that are denied for lack of funds will incur a fee of \$35.00 per transaction. Please be aware we offer discounted prices for certain packages of services. Please note that prices can change at any time.

Cancellation Policy

To ensure scheduling availability for all clients, please provide 48 hour notice of all appointment cancellations. A minimum of \$120 will be charged for failure to provide 48 hour notice. Thank you for your understanding.

Gift Certificates

The Healing Atelier offers gift certificates for products and services. For inquiries, please call The Atelier.

Tri-lingual Services

To ensure that clients feel at ease and can communicate comfortably, The Healing Atelier offers services in English, Spanish, and French.

Telephone Consultations / House Calls

Telephone consultations are available for new and existing clients. All telephone consultations are billed at the same rate as in- person visits. House calls and treatments are available for clients unable to visit The Atelier. Standard fees apply plus travel expenses.

Scent-free Zone

The Healing Atelier is a scent-free environment, in compliance with the Interior Air Environment Guidelines produced by the Center for Disease Control (CDC- Please refer to our website: www.thehealingatelier.com). Please refrain from wearing perfumes, colognes, or scented hair and personal care products. Please wear scent-free clothes - no fabric softeners, scented detergents, dryer sheets, dry-cleaned fabrics. (ie., Bounce, Tide, All, etc...). Thank you.

I have read and understand the above policies. I agree to abide by the scent-free policy as best I can. I have also received, read and signed the waiver/release form and the CA SB577 compliance form.

Patient / Guardian Signature

Date: _____

Patient / Guardian Printed Name

THANK YOU FOR YOUR PATRONAGE