



Confidential Health History Form

Name _____ Date _____ Referred by _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Occupation _____ Phone Number _____

E-mail: _____ Phone _____

Permission to consult with Physician Yes or No Physician: _____

Emergency Contact _____ Relationship _____ Phone _____

Y_N_ Have you received energy therapy before? _____

Y_N_ Do you wear contact lenses? _____

Y_N_ Do you wear dentures? _____

Y_N_ Do you have any skin conditions; Allergies? If yes what? _____

Y_N_ Are you pregnant; If yes what stage? _____

Y_N_ Do you exercise regularly? How often? _____

Y_N_ Do you take any medications? (include aspirin, ibuprofen) _____

Y_N_ Have you ever had surgery? (explain) _____

Y_N_ Do you have headaches or migraines? _____

Y_N_ Do you have Arthritis? Osteo or Rheumatoid? _____

Y_N_ Do you have heart problems? If yes explain _____

Y_N_ Do you back or spine pain? If yes explain _____

Y_N_ Do you have indigestion? _____

Y_N_ Do you have constipation or diarrhea? _____

Y_N_ Do you have liver problems? _____

Y_N_ Do you have kidney problems? _____

Y_N_ Do you have Cancer? _____

Y_N_ Do you have female organ problems? _____

Y_N_ Do you have male organ problems? _____

Y_N_ Do you experience depression? _____

Y_N_ Do you have any other medical issues that your practitioner should know about; if

yes

explain _____

It is my choice to receive Vibrational Medicine. I realize the treatment being given to me is for wellness of my mind, body, and spirit. I understand that my Vibrational Medicine Practitioner does not diagnose illness, disease, or any other mental or physical disorders; nor do they prescribe medical treatments or pharmaceuticals or perform spinal manipulations. I acknowledge that Vibrational Medicine is not a substitute for medical examination or diagnoses and that it is recommended that I see my primary healthcare provider for that service. I have stated all of my medical conditions that I am aware of and will update my Vibrational Medicine Practitioner of any changes in my health status.

Signature _____ Date _____