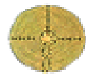


Inner Harbour Health & Healing

www.InnerHarbourHealing.com

# Confidential Health Profile

The information from this profile is used to develop an understanding of circumstances and events that have had an impact on your health; it will help determine how to best treat your health concerns.
Please fill it out to the best of your ability.

## Contact & Personal Information

Name: ____________________ O male O female

Address: ____________________

____________________

____________________

____________________

Contact: home: ____________ work: ____________

mobile: ____________ email: ____________

Occupation: ____________________

Birth date: ____________________ age: ________

## 1° Health Care Provider

Name: ________________

Phone: ________________

## Emergency contact

Name: ________________

Phone: ________________

Relationship: ____________

## Referred by:

____________________

## Health Concerns

What brings you to seek treatment? What aspects of your health concern you today?

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**Conditions**: Please indicate which conditions you have had in the past (P), which you have currently (C) and when they started.

O Abcess
O AIDS
O Infection
O STD
O Allergies
O Heart Disorder
O Heart attack
O High cholesterol
O TIA
O Lung Disorder
O Asthma
O Bronchitis
O Pneumonia/Pleurisy
O Gastro-Intestinal Disorder
O Heartburn
O Ulcer
O Crohn's Disease/ Colitis
O Hemorrhoids
O Liver Disorder
O Hepatitis

O Gallbladder Disorder
O Metabolic Disorder
O Obesity
O Endocrine Disorder
O Adrenal Disorder
O Thyroid Disorder
O Diabetes
O Hypoglycemia
O Spleen Disorder
O Anemia
O Connective Tissue Disord.
O Arthritis
O Nerve Disorder
O Insomnia
O Chronic Pain
O Psychological Disorder
O Kidney Disorder
O Kidney Stones
O Urinary Disorder
O Urinary Tract Infection

O Gynecological Disorder
O Vaginal Infection
O Menstrual Disorder
O Hearing Disorder
O Eye Disorder
O Cataracts / Glaucoma
O Skin Disorder
O Eczema
O Psoriasis
O Chronic Pain
O Other______________
O Other______________
O Other______________
O Impaired Immune system
O Hyper-functioning Immune system
O Cardiac Pacemaker
O Seizures
O Bleeding Disorder

**Personal Symptoms** Next to any current symptom mark
**1** if you experience it occasionally or mildly **2** if frequently or severely **3** if it is persistent **+** if it is increasing

| Women Only: | Men Only: |
|---|---|
| O abnormal PAP smear<br>O breast lump<br>O breast pain<br>O breast discharge<br>O vaginal discharge<br>O other: | O weak urinary stream<br>O prostate hypertrophy<br>O impotence<br>O premature ejaculation<br>O seminal emissions<br>O other: |

| Menstrual Cycle | | |
|---|---|---|
| | Number of days between periods: | |
| | Duration of bleeding: | |
| O irregular periods<br>O bleeding between periods<br>O early periods | Quality of blood:<br>O light red<br>O bright red<br>O other (please describe) | <br>O dark red<br>O clotted |
| O PMS | If you experience PMS please describe your symptoms: | |
| O hysterectomy<br>O no periods<br>O menopausal | If you are menopausal please describe the range of your symptoms past (p) and current (c): | |

| Pregnancy & Conception | | |
|---|---|---|
| Are you pregnant? | O yes | O no |
| Are you trying to become pregnant? | O yes | O no |

If no, when you are sexually active what kinds of birth control have you used in the past, and do you use now?

Please note the number of pregnancies you have had, and the number of deliveries, along with any notable information:

## Personal Symptoms (cont'd.): Next to any current symptom mark

**1** if you experience it occasionally or mildly **2** if frequently or severely **3** if it is persistent **+** if it is increasing

### General

- O susceptible to colds, etc
- O lymphatic swelling
- O fever
- O chills
- O alternating fever & chills
- O night sweats
- O unusual daytime sweating
- O hot palms or foot soles
- O often thirsty
- O seldom thirsty
- O weight gain
- O weight loss
- O fatigue
- O insomnia
- O disturbed sleep
- O excessive sleep
- O vivid dreams
- O other:

### Hair, Skin and Nails

- O excessive hair loss
- O brittle hair / nails
- O early greying hair
- O rashes
- O itchiness
- O dry skin
- O acne
- O changes in moles
- O easily bruised
- O swelling (might be at joints)
- O unusual bleeding
- O other:

### Head and Neck

- O headaches
- O dizziness
- O loss of balance
- O other:

### Eyes and Ears

- O blurred or failing vision
- O night blindness
- O dry eyes
- O weepy eyes
- O visual spots
- O pain in eyes
- O decreased hearing
- O ringing in the ears
- O ear pain
- O other:

### Nose, Throat and Mouth

- O change in sense of smell
- O frequent sneezing
- O nasal discharge or infection
- O nose bleeds
- O sore throat
- O hoarseness
- O difficulty in swallowing
- O change in sense of taste
- O chronic resting bitter taste
- O loose teeth
- O bleeding gums
- O tooth or gum pain
- O mouth or tongue ulcers
- O other:

### Nervous System

- O fainting
- O tremors
- O seizures
- O paralysis
- O other:

### Heart, Lungs and Chest

- O irregular heart beat
- O rapid heart beat
- O palpitations
- O sensation of tightness
- O chest pain / discomfort
- O swollen ankles
- O cough
- O dry cough
- O productive cough
- O coughing blood
- O shortness of breath
- O wheezing / asthma
- O pain in sides of ribcage
- O other:

### Consciousness and Mentals

- O difficulty concentrating
- O poor memory
- O other:

### Muscles and Joints: Do you have pain, weakness, tingling or numbness:

- O head/neck/ shoulder/ arm/ hand
- O low back / hips/ leg/ feet
- O knees
- O muscle cramps
- O flaccid muscles
- O heavy limbs
- O swollen joints
- O hot joints
- O cold extremities
- O chronic tension in:
- O other:

### Appetite and Digestive System

- O poor appetite
- O large appetite
- O binge eating
- O nausea
- O belching
- O acid reflux
- O indigestion
- O vomiting
- O vomiting blood
- O stomach pain
- O abdominal pain
- O abdominal gas / bloating
- O loose stools
- O diarrhea
- O constipation
- O bloody or black stools
- O other:

### Urinary and Genital Systems

- O frequent daytime urination
- O frequent nighttime urination
- O urgent urination
- O incontinence
- O difficult urination
- O painful urination
- O cloudy urine
- O bloody urine
- O genital pain or itch
- O genital discharge or sores
- O painful intercourse
- O low/excessive sex drive
- O other:

# Factors Affecting Your Health

| Family History: As some family health conditions can have a genetic impact on your constitution, please check all the conditions which any blood relations have had. | | |
|---|---|---|
| O Arthritis / Gout | O Heart Disease | O Seizures |
| O Asthma | O High Blood Pressure | O Thyroid Problems |
| O Bronchitis | O Kidney Disease | O Tuberculosis |
| O Cancer | O Liver Disease | O Other________________ |
| O Diabetes | O Stroke | O Other________________ |

| Infancy & Childhood: Please mark all that apply | | | | | |
|---|---|---|---|---|---|
| Birth | O Home or, | O Hospital Delivery | Childhood Illnesses | O Measles | O Chickenpox |
| | O Birth Canal or, | O Cesarean | | O Mumps | O Rheumatic Fever |
| | O Breast or, | O Bottle Fed | | O Rubella | O Other__________ |

| Immunizations: Please mark all that apply | | | | | |
|---|---|---|---|---|---|
| O Measles | O Rubella | O Smallpox | O Yellow Fever | O Influenza | O Typhoid |
| O Mumps | O Diptheria | O Tetanus | O Whooping cough | O Meningitis | O Polio |

**Significant accidents, falls and sports injuries** Please list:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Surgeries and Hospitalizations** Please list with approximate date:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Prescriptions and supplements** Please list any that you are currently taking. If you need more room, please attach another page.

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Allergies** Please list any that you have currently:

______________________________________________

______________________________________________

## Stress & Emotions

What stressors are you currently aware of in your life? (If you need more room please attach another page.)

Do you consider stress a problem for you? O Yes O No

In Oriental Medicine, habitual emotions can help distinguish patterns of imbalance.
Do you find yourself frequently affected by any of the following emotions?

| | | | | |
|---|---|---|---|---|
| O fear | O longing | O anger/frustration | O joy | O sympathy |
| O anxiety | O grief | O indecision | O clarity | O worry |
| O paranoia | O disdain | O resentment | O bitterness | O disgust |
| O calm | O impartial | O Other___________ | | |

## Health Habits & Wellbeing

**Health Practices** Are there any personal practices (i.e.: dancing, meditation, yoga, etc.) which you engage in for your health and wellbeing? If so, please list them.

**Health Practitioners** Please give the names and modalities of any health practitioners whom you have consulted for your health concerns.

On a scale of 1-10 for:

| | | |
|---|---|---|
| Energy | 0 being the least you have ever felt, 10 being the most, please rate and use a few words to describe your current general functioning level of energy: | |
| Sleep | 0 being the least restful sleep you have ever had, 10 being the most, please rate and use a few words to describe your current general experience of sleep: | |
| Exercise | 0 being the least amount of exercise you have ever done on a regular basis, 10 being the most, please rate and describe your current general exercise habits. | |

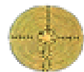
## Health Habits & Wellbeing (cont'd.)

| **Diet** Please describe what you tend to eat over the course of a normal day and include your style of eating (i.e.: grazing, meals, binges, etc) | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| **Substances** Please indicate which substance you intake as well as the amount, and frequency. | | |
| sugar | | |
| artificial sweeteners | | |
| salt | | |
| fats | | |
| caffeine | | |
| alcohol | | |
| tobacco | | |
| recreational drugs | | |
| other | | |
| **Cleansing or Fasting** Please indicate if you have ever been on a cleanse or fast, what it was and your results. | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Additional Information** If there is anything which you feel is important relative to your overall health and would like to add, please do so below. |
|---|
| |
| |
| |
| |
| |
| |

Patient signature: ______________________

Date: ______________________



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