Pamyla Love
Spiritual & Vibrational Healing

Health Story

Thank you for taking the time to complete this form. The information is important in the assessing your current situation and assist in facilitating the healing journey.

Date: _____
(Month) (Day) (Year)

Name: _____
(Last) (First) (Initial) (Preferred name)

Address: _____ **Apt. #**_____ **City:**_____

Province:_____ **Postal Code:** _____ **Email:**_____

Telephone: (home) _____ **(work)** _____ **(cell)** _____

Gender: ☐ **Male** ☐ **Female** **Age:** ____ **Date of Birth:** _____ **Birthplace:** _____
(Month) (Day) (Year)

Religion or personal philosophy: _____

Occupation: _____

Marital Status: _____**No. of Dependents:** _____

Preferred form of contact for reminder/follow-up calls: ☐**Home** ☐**Work** ☐**Email** ☐**Other – Please specify**

Emergency Contact Name: _____

Relation: _____ **Telephone:** _____

Name of Medical Doctor: _____

Address: _____

City: _____ **Telephone:** _____

How did you hear of Pamyla Love Holistic Services? _____

Were you referred to me, if so by whom so we can thank them?

_____

Would you like to receive information about upcoming workshops or events?
☐ **No** ☐ **Yes (please ensure your email is listed above)**

General:

Height: _____ Weight: _____ Max Weight: _____ When? _____

Are you currently under the care of another healthcare provider? ☐ No ☐ Yes, specify _____
_____

What are the main concerns?
1._____

2._____

3._____

Please list all medications (prescription, over-the-counter) you are currently taking:

Medication (please indicate brand)	**Dose/Quantity per day**	**Why are you taking this product?**

Please list all natural products (vitamins, minerals, herbal medications, Asian medicine, homeopathic) you are currently taking:

Natural Product (please indicate brand)	**Dose/Quantity per day**	**Why are you taking this product?**

Have you ever experienced adverse effects or an allergic reaction to any of the medications/natural products? ☐ No ☐ Yes, specify: _____

Other treatments or health care providers tried in the past: _____

_____

Have you ever used any of the following in the last 5 years?

☐ Anesthesia
☐ Antacids
☐ Anti-depressants
☐ Antibiotic for more than 2 weeks
☐ Blood Thinners
☐ Chemotherapy/Radiation
☐ Cortisone or other steroids
☐ Diuretics
☐ Drugs for arthritis (Vioxx, Celebrex, etc.)
☐ Epidural
☐ Hormone Therapy (including fertility treatments)
☐ Laxatives or stool softeners
☐ Pain relievers (Aspirin, Ibuprofen, etc.)
☐ Recreational Drugs Type(s):_____
Frequency:_____
☐ Sleeping pills or sedatives
☐ Stimulants (Viagra, etc.)
☐ Thyroid Medication

General Review of Body Systems:

Please circle "**C**" for current condition and "**P**" if had in the past.

Cancer	C	P
Chronic Fatigue	C	P
Endometriosis	C	P
Epilepsy	C	P
Excessive hair loss	C	P
Fibromyalgia	C	P
Lupus	C	P
Lyme Disease	C	P
Mental Illness	C	P
Parasites	C	P
Rapid weight gain/loss	C	P
Sensitivity to cold	C	P
Strep Throat		
Sudden tiredness/weakness	C	P
Time of Day: _____		
Sweat easily/excessively	C	P

Skin:

	C	P
Acne	C	P
Boils	C	P
Dry Skin	C	P
Hives	C	P
Lice	C	P
Loss of Body Hair	C	P
New Moles/Changes in old moles	C	P
Other: _____		
Night Sweats	C	P
Psoriasis	C	P
Rashes	C	P
Scabies	C	P

Head:

	C	P
Discharge	C	P
Dizziness	C	P
Earache	C	P
Excess Wax	C	P
Headache	C	P
Hearing Loss	C	P
Infections	C	P
Injuries	C	P
Itching	C	P
Loss of Balance	C	P
Ringing	C	P
Other:_____		

Mouth & Throat:

	C	P
Dental Cavities	C	P
Silver Fillings ☐ Gold Crowns ☐		
Other: _____		
Other metal appliances in mouth/jaw:	C	P
_____		
Dry Mouth	C	P
Grinding teeth	C	P
Gum problems	C	P
Hoarseness	C	P
Jaw clicks	C	P
Many sore throats	C	P
Metallic taste in mouth	C	P
Sores on lips/tongue/mouth	C	P
Surgery	C	P

Neck:

	C	P
Goiter	C	P
Lump(s)	C	P
Pain	C	P
Stiffness	C	P
Swollen glands	C	P

Nose & Sinuses:

	C	P
Hay fever	C	P
Nose Bleeds	C	P
Loss of Smell	C	P
Injury	C	P
Stuffiness	C	P
Allergies	C	P
Sinus Problems	C	P
Obstructions	C	P
Nasal Polyps	C	P

Eyes:

Glasses/contacts ☐ Yes ☐ No

What age? _____ Near sighted ☐ Far sighted ☐

	C	P
Impaired vision	C	P
Double vision	C	P
Redness	C	P
Cataracts	C	P
Discharge	C	P
Light Sensitivity	C	P
Loss of Sight	C	P
Glaucoma	C	P
Itchiness	C	P
Tearing or dryness	C	P
Blurring	C	P
Blind spots	C	P
Colour blind	C	P

Cardiovascular:

	C	P
Ankle swelling	C	P
Chest pain/angina	C	P
Heart attack	C	P
Heart disease	C	P
High blood pressure	C	P
High cholesterol	C	P
Murmurs	C	P
Palpitations/Irregular heart beat	C	P
Rheumatic fever	C	P
Other: _____	C	P

Gastrointestinal:

	C	P
Abdominal pain	C	P
Appendicitis	C	P
Belching/gas	C	P
Black stool	C	P
Change in appetite	C	P
Change in bowel movements	C	P
Change in thirst	C	P
Colitis	C	P
Constipation	C	P
Diarrhea	C	P
Difficulty swallowing	C	P
Food allergies	C	P
Heartburn	C	P
Hepatitis	C	P
Hernias	C	P
Indigestion/bloating	C	P
Jaundice	C	P
Nausea/vomiting	C	P
Rectal bleeding/bloody stool	C	P
Spitting up blood	C	P
Other: _____		
Food desires/cravings: _____		
_____		
Foods that disagree: _____		
_____		
Food aversions: _____		
_____		
Anemia	C	P
Blood transfusions	C	P
Easily bruise/ bleed	C	P
Lymph node	C	P
Sickle Cell Anemia	C	P

Respiratory:

	C	P
Asthma	C	P
Bronchitis	C	P
Chest pain	C	P
Chronic mucous in throat	C	P
Chronic or frequent cough	C	P
Coughing blood	C	P
Difficulty breathing	C	P
Emphysema	C	P
Frequent colds	C	P
Hayfever	C	P
Pain on breathing	C	P
Pleurisy	C	P
Pneumonia	C	P
Shortness of breath	C	P
Shortness of breath at night	C	P
Shortness of breath lying down	C	P

Peripheral Vascular:

	C	P
Cold hands/feet	C	P
Deep leg pain	C	P
Hemorrhoids	C	P
Varicose Veins	C	P
Thrombophlebitis	C	P
Other: _____	C	P

Breasts: C P

	C	P
Fibrous tissue	C	P
Lumps	C	P
Pain	C	P
Tenderness	C	P
Do you self-exam ☐ Yes ☐ No	C	P
Other: _____	C	P

Reproductive:

	C	P
Sexual Difficulties	C	P
Chlamydia	C	P
Gonorrhea	C	P
Genital Infection	C	P
Herpes	C	P
Syphilis	C	P
Non-specific venereal disease	C	P
Warts on genitals	C	P

Reproductive – Males:

	C	P
Prostate disease	C	P

Reproductive – Females:

Menopause ☐ Yes ☐ No If yes what age? _____
Symptoms: _____
_____
_____
Birth control- type _____
How long _____
Menses: Regular cycle ☐ Yes ☐ No
Length of cycles _____ days
Duration of flow _____ days
☐ light ☐ medium ☐ heavy ☐ clots
Pain or cramps ☐ Yes ☐ No
☐ before ☐ after flow starts
First day of last menses: _____
Age at first menses: _____

Pre-menstrual symptoms:

	C	P
Bloating	C	P
Breast tenderness	C	P
Weight gain	C	P
Increase in appetite	C	P
Decrease in appetite	C	P
Depression	C	P

Other: _____
No. of pregnancies: _____
No. of miscarriages: _____
No. of abortions: _____
Pregnancy complications: ☐ Yes ☐ No
Explain: _____

	C	P
Frequent yeast/other infections	C	P
Polycystic ovaries	C	P
Uterine fibroids	C	P

Urinary:

	C	P
Abnormal thirst	C	P
Bladder/kidney disease/infections	C	P
Blood/sugar/pus in urine	C	P

Colour of urine:
☐ Pale ☐ Yellow ☐ Dark ☐ Frothy

	C	P
Decrease in flow	C	P
Frequent infections	C	P
Inability to urinate	C	P
Inability to hold urine	C	P
Increased frequency	C	P
Kidney stones	C	P
Pain on urination	C	P
Swelling of feet/hands/ankles	C	P

Other: _____

Neurological:

	C	P
Areas of numbness/tingling/paralysis	C	P
Concussion/head injury	C	P
Fainting	C	P
Hallucinations/mental confusion	C	P
Involuntary movements	C	P
Loss of balance	C	P
Loss of coordination	C	P
Loss of memory/poor memory	C	P
Muscle weakness	C	P
Seizures /Convulsions	C	P
Speech problems	C	P
Poor concentration	C	P

Musculoskeletal:

	C	P
Arthritis/Rheumatism	C	P
Back pain	C	P
Broken bones	C	P
Foot pain	C	P
Joint pain or stiffness	C	P
Muscle cramps/spasms	C	P
Numbness/tingling	C	P
Osteoporosis	C	P
Shoulder pain	C	P
Weakness	C	P

Other: _____

Endocrine:

Thyroid problems	C	P
Diabetes	C	P
Hormone therapy	C	P
Hypoglycemia	C	P

Other: _____

Blood/Lymphatics:

Anemia	C	P
Blood transfusions	C	P
Easily bruise/ bleed	C	P
Lymph node	C	P
Sickle Cell Anemia	C	P

Other: _____

Psycho/Social

Anxiety/Nervousness	C	P
Attempted suicide	C	P
Depression	C	P
Easily angered/Easy to cry	C	P
Mood swings	C	P
Phobias	C	P
Sleep problems	C	P
Tension	C	P

Have you ever had psychiatric/psychological counseling? ☐ Yes ☐ No

Do you express your emotions/feelings easily? ☐ Yes ☐ No

Lifestyle/Habits:

How content are you with your life? (1=low 10=high) 1 2 3 4 5 6 7 8 9 10

Do you smoke now? ☐ Yes ☐ No How many cigarettes per day? _____

Have you ever smoked? ☐ Yes ☐ No How many cigarettes per day? _____

Have you ever used recreational drugs? ☐ Yes ☐ No

If so, what drugs and how long did you use them? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week?_____

Do you drink: coffee? ☐ Yes ☐ No Cups/day: Black tea? ☐ Yes ☐ No Cups/day: _____

Rate your energy level (1=low 10=high) 1 2 3 4 5 6 7 8 9 10

At what time of day is your energy high ☐ AM ☐ midday ☐ PM low ☐ AM ☐ midday ☐ PM

Do you usually wake up feeling refreshed? ☐ Yes ☐ No Do you have any problems falling asleep? ☐ Yes ☐ No

Hours of sleep/night: _____ Number of times wake up during the night: _____

Do you have any surgical implants (Cosmetic, medical, etc.)? _____

Do you participate in sports or have any hobbies or activities that give you relaxation at least 3 hours weekly? ☐ Yes ☐ No

If yes, what type of activities?

1. _____ No. of hours? _____
2. _____ No. of hours? _____
3. _____ No. of hours? _____
4. _____ No. of hours? _____

What level of personal stress are you experiencing at the present moment? (1=low 10=high) 1 2 3 4 5 6 7 8 9 10

What are your top three stressors in your life? _____

_____

Has there been an event in your life that you have never recovered from? ☐ No ☐ Yes – Specify: _____

_____

Environmental Toxins:

Do you have any mercury dental fillings?	☐ No ☐ Yes
Have you ever lived near a polluted area/power line?	☐ No ☐ Yes
Are you particularly sensitive to scents (Perfumes, gasoline, etc)?	☐ No ☐ Yes
Have you ever experienced health problems after doing renovations or having your lawn sprayed with pesticides?	☐ No ☐ Yes
Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at work, home (renovations, hobbies, etc.) or while traveling?	☐ No ☐ Yes

1. Why did you choose these services?

_____
_____

2. What do you know about my approach?

_____
_____

3. What three expectations do you have from this visit?

_____
_____
_____

4. What long-term expectations do you have from working with these modalities?

_____
_____

5. What expectations do you have of me personally as your practitioner?

_____
_____

6. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed) 1 2 3 4 5 6 7 8 9 10

7. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your well-being? (please list)

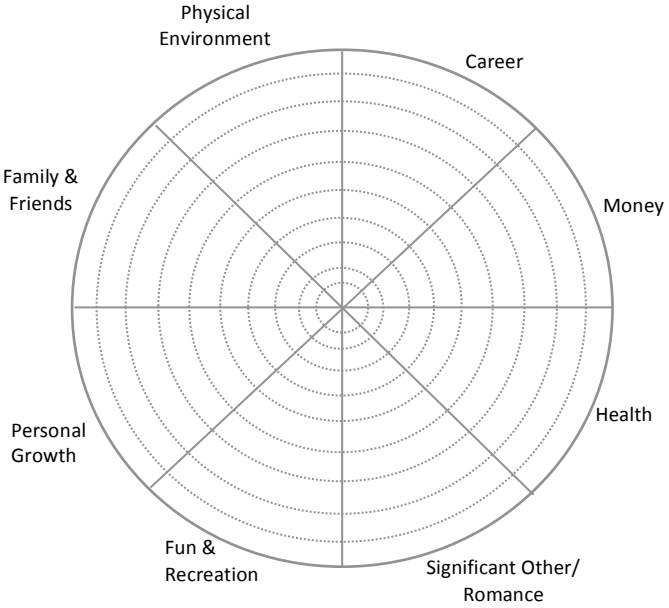
_____
_____

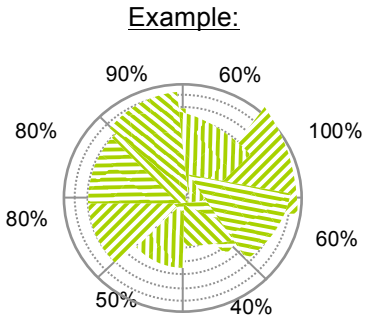
b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list) _____
_____

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.





8. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

_____
_____

9. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____
_____

10. What do you LOVE to do?

_____
_____
_____

11. Are there any cultural, religious, or spiritual beliefs or practices to be aware of which could affect this treatment?

_____
_____