HEALTH QUESTIONNAIRE

Optimal Healing Pathways

Bio-Energetic Assessments - Holistic Alternative Health Care

Last Name_______________________________ **First** ____________________ **Date** ______________

If minor under 18, name of parent/guardian ____

Address ___________________________________ **City** ________________**State** _______ **Zip** _______

e-Mail ____ **Cell** __________________

Age ____ **Date of Birth** ____/____/____ **Height** ______ **Weight** _______ **Gender** **M** **F** **Marital Status** **S** **M** **D** **W**

Employer/School ____ **Occupation** _______________

Spouse's Name ____ **No. of Children, if any** _________

Emergency Contact Name ___________________________________ **Phone** __________________

Whom may we thank for referring you to OHP? ____

PLEASE LIST YOUR MAIN HEALTH COMPLAINTS IN ORDER OF IMPORTANCE

FIRST (worst) health concern: ____

SECOND health concern: ____

THIRD health concern: ____

SURGERIES / ACCIDENTS / INJURIES

Blood Transfusion?

Surgeries - Type of procedure:

______________________________ **Date** ______________ **Y** **N**

______________________________ **Date** ______________ **Y** **N**

______________________________ **Date** ______________ **Y** **N**

Accidents (Auto / Home / Work) / **Injuries**

______________________________ **Date** ______________ **Y** **N**

______________________________ **Date** ______________ **Y** **N**

______________________________ **Date** ______________ **Y** **N**

FAMILY HISTORY - Check ONLY those that apply

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Aneurysm
- ☐ Asthma
- ☐ Cancer
- ☐ Chrohn's Disease
- ☐ Colitis
- ☐ Diabetes
- ☐ Dialysis / Renal failure
- ☐ Disk Problems
- ☐ Diverticulitis
- ☐ Emotional Issues
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fissures
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Kidney Disorders
- ☐ Low Back Pain
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Musculoskeletal Issues
- ☐ Nervousness
- ☐ Scoliosis
- ☐ Sinus Trouble
- ☐ Stomach Issues
- ☐ Thyroid Disturbances
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other - Use back of page

INSTRUCTIONS

Please ***Circle the number*** next to the symptom that applies to you.

1) **Mild** - Occurring Monthly 2) **Moderate** - Occurring Weekly 3) **Severe** - Occurring Daily

NO. 1 S - NERVOUS SYSTEM - pH ISSUES

Acid foods upset	1	2	3
Cold sweats often	1	2	3
Dry Mouth - Eyes - Nose	1	2	3
Extremities cold, clammy	1	2	3
Fever easily raised	1	2	3
Heart pounds after retiring	1	2	3
Keyed up - fail to calm	1	2	3
Mental alert, quick	1	2	3
"Nervous" Stomach	1	2	3
Neuralgia-like pains	1	2	3
Pulse speeds after meals	1	2	3

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STRESS? YES____ NO____

NO. 2 P - NERVOUS SYSTEM - Calcium

Circulation poor, sensitive to cold	1	2	3
Constipation, dirrhea-alternating	1	2	3
Difficulty swallowing	1	2	3
Digestion rapid	1	2	3
Eyelids swollen - puffy	1	2	3
Indigestion soon after meals	1	2	3
Joint stiffness after rising	1	2	3
Muscle-leg-toe cramps at night	1	2	3
Perspire easily	1	2	3
Subject to colds, asthma, bronchitis	1	2	3
Vomiting frequent	1	2	3

ARE YOUR SYMPTOMS MADE WORSE BY EMOTIONAL STRESS? YES____ NO____

NO. 3 PANCREAS / BLOOD - Sugar Regulation

Abnormal craving for sweets/snacks	1	2	3
Afternoon headaches	1	2	3
Awaken after a few hours of sleep	1	2	3
Crave candy or coffee in afternoons	1	2	3
Difficult to get back to sleep	1	2	3
Eat when nervous	1	2	3
Faintness if meals delayed	1	2	3
Get "shaky" if hungry	1	2	3
Heart palpitates if meals are missed or delayed	1	2	3

NO. 4 CARDIOVASCULAR

Aware of breathing heavy	1	2	3
Bruise easily - purple spots	1	2	3
Dull pain in chest / radiates to left arm, worse on exertion	1	2	3
Hands / feet go to sleep easily - numbness	1	2	3
Muscle cramps, worse in exercise	1	2	3
Opens window in closed rooms	1	2	3
Shortness of breath on exertion	1	2	3
Sigh frequently - air hunger	1	2	3
Susceptibility to colds / fevers	1	2	3
Swollen ankles, worse at night	1	2	3
Tendency to anemia	1	2	3
Tension under breastbone or tightness feeling, worse on exertion	1	2	3

NO. 5 LIVER AND GALLBLADDER

Biliousness	1	2	3
Bitter metallic taste in mouth in the mornings	1	2	3
Bowel movements painful, difficult	1	2	3
Dry skin	1	2	3
Greasy foods upset	1	2	3
History of GB attacks, gallstones	1	2	3
Laxatives used often	1	2	3
Pain between shoulder blades	1	2	3
Skin rashes - frequent	1	2	3
Sneezing attacks	1	2	3
Stools light colored	1	2	3

NO. 6 GASTROINTESTINAL

Burning stomach feeling, eating relief	1	2	3
Coated tonque	1	2	3
Gas shortly after eating	1	2	3
Indigestion 1/2 - 1 hr after eating	1	2	3
Lower bowel gas hours after eating	1	2	3
Stomach "bloating" after eating	1	2	3

NO. 7 REPRODUCTIVE - Female ONLY

Acne, worse at menses	1	2	3
Depressed feeling before period	1	2	3
Menopause / hot flashes	1	2	3
Menses scanty	1	2	3
Menstruate too frequently	1	2	3
Menstruation excessive / prolongued	1	2	3
Night urination / frequent	1	2	3
Painful breasts	1	2	3
Painful menses	1	2	3
Premenstrual tension	1	2	3
Tire too easily	1	2	3
Urination difficult	1	2	3
Vaginal discharge	1	2	3
Very easily fatigued	1	2	3

REPRODUCTIVE - Male ONLY

Diminished sex desire	1	2	3
Feeling -incomplete bowel movement	1	2	3
Leg nervousness at night	1	2	3
Pain - inside leg / heel	1	2	3
Prostate trouble	1	2	3

NO. 8 ENDOCRINE

(A) High - Thyroid

Can't gain weight	1	2	3
Flush easily	1	2	3
Heart palpitates	1	2	3
Highly emotional	1	2	3
Insomnia	1	2	3
Intolerance to heat	1	2	3
Inward trembling	1	2	3
Nervousness	1	2	3
Night sweats	1	2	3
Pulse fast at rest	1	2	3

(B) Low - Thyroid

Constipation	1	2	3
Decrease in appetite	1	2	3
Headaches upon rising	1	2	3
Impaired hearing	1	2	3
Increase in weight	1	2	3
Mental sluggishness	1	2	3
Ringing in ears	1	2	3
Slow pulse - below 65	1	2	3

(E) High - Adrenals

Dizziness	1	2	3
Headaches	1	2	3
Hot flushes	1	2	3
Increased blood pressure	1	2	3
Masculine tendencies (female)	1	2	3
Sugar in urine (not diabetes)	1	2	3

(C) High - Pituitary / Pineal / Hypothalamus

Decrease sugar tolerance	1	2	3
Failing memory	1	2	3
Heaches - "spliting/rending" type	1	2	3
Increased sex desire	1	2	3
Low blood pressure	1	2	3

(D) Low - Pituitary / Pineal / Hypothalamus

Abnormal thirst	1	2	3
Increase sugar tolerance	1	2	3
Intestinal bloating	1	2	3
Sex desire reduced / lacking	1	2	3
Tendency to ulcers / colitis	1	2	3
Weight gain around hips/waist	1	2	3
Women: Menstrual disorders	1	2	3
Young girls: Lack of menstrual	1	2	3

(F) Low - Adrenals

Allergies - Tendency to asthma	1	2	3
Arthritic tendencies	1	2	3
Brown spots / skin bronzing	1	2	3
Chronic fatigue	1	2	3
Crave salt	1	2	3
Exhaustion - muscular / nervousness	1	2	3
Low blood pressure	1	2	3
Perspiration increases	1	2	3
Respiratory disorders	1	2	3
Tendency to hives	1	2	3
Weakess / fatigue	1	2	3

NO. 9 RESPIRATORY

Bronchitis (frequent)	1	2	3
Chest pain	1	2	3
Chronic cough	1	2	3
Coughing up blood	1	2	3
Coughing up phlegm	1	2	3
Difficulty breathing	1	2	3
Infections settle in lungs	1	2	3
Pain around ribs	1	2	3
Sensitive to smog	1	2	3
Shortness of breath	1	2	3

NO. 10 KIDNEY AND BLADDER

Cloudy / Bloody urine	1	2	3	Pain / burning when urinating	1	2	3
Difficulty passing urine / UTI	1	2	3	Rarely needs to urinate	1	2	3
Dripping after urination	1	2	3	Strong smelling urine	1	2	3
Frequent urination	1	2	3	Urination when coughing / sneeze	1	2	3

NO. 11 IMMUNITY - 5 + = NO. 9

Allergies	1	2	3	Poor wound healing	1	2	3
Bumpy skin on back / arms	1	2	3	Post nasal drip	1	2	3
Catch colds / flu easily	1	2	3	Slow to recover from cold / flu	1	2	3
Food sensitivities	1	2	3	Swollen lymph glands	1	2	3
Gets boils / styes	1	2	3	Swollen tongue	1	2	3
Hyperactivity	1	2	3	Throat infections	1	2	3
Inflammed / bleeding gums	1	2	3				

Please List ALL Rx DRUGS / Medications / Supplementations you are presently taking: ___________________________

NOTICE OF UNDERSTANDING AND AGREEMENT

I understand that I am not seeking to consult with Optimal Healing Pathways (OHP) or with Nita Bellafiore, ND for medical diagnosis or medical treatment procedures. The services performed at this clinic are, at all times, restricted to help me gain a better understanding of my level of health so that I will have a greater self-awareness and be able to use a self-care prograr and take responsibility of my own health.

I understand that the recommendations, discussions, sale of homeopathic remedies and/or nutritional supplements pertain to the energetic concept of nutritional balance and do not relate in the context of any specific ailment or condition.

The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines for the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a License may be required.

CONSENT TO RENDER SERVICES TO A MINOR OR DEPENDENT

I do hereby give my full authority and consent to the staff at OHP to assess Bio-Energetically DOB ________
NAME OF MINOR ____ DATE ________
PARENT / GUARDIAN SIGNATURE ____ DATE ________
WITNESS ____

FINANCIAL PROFILE AND PAYMENT POLICY COMMITMENT

Resposible party for payment: SELF ☐ OTHER ☐ **(OHP Does NOT File Insurance)**

Payment Method: CASH ☐ CHECK ☐ DEBIT ☐ HAS ☐ FSA ☐
VISA ☐ M/C ☐ AMEX ☐ DISC ☐

I Agree to Pay for incurred services rendered and products purchased at OHP.

CLIENT SIGNATURE ____ DATE ________

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