STAR SPA

Natural Health & Aesthetics

FUNCTIONAL HEALTH ASSESSMENT

Name _____ Age _____ Sex M F Date _____

Address _____ Blood Type: A B AB O (+) (-) Unsure?

City _____ State _____ Zip _____ Email _____

Phone _____ Work Phone _____ Mobile _____ Fax _____

Date of Birth _____ Ht _____ Wt _____ Wt at 20 yr _____

Marital Status _____ Children _____ Education _____

Occupation _____ Hobbies _____ Chemically Sensitive? _____

Emergency Contact _____ Phone _____

Known Allergies _____

_____

Chief Complaints _____

_____

_____

How did you hear of us or who referred you _____

Present Medications (prescription and non-prescription _____

_____

Vitamin/Mineral Supplements _____

LIFE STYLE HISTORY (PLEASE) CIRCLE THE ONE WHICH FITS BEST)

Health: **VERY** **GOOD** **MODERATE** **POOR** **VERY POOR**

Health: **VERY** **GOOD** **MODERATE** **POOR** **VERY POOR**

Fat/Cholesterol Intake: **NONE** **SOME** **REGULAR** **OFTEN**

Exercise (please also indicate number of times per week): Type _____ **NONE** **SOME** **REGULAR** **OFTEN**

Stress Levels: **NONE** **SOME** **REGULAR** **OFTEN**

Alcohol Intake (if you drink please indicate number of drinks per week): _____ (beer, wine, liquor) # years: _____

Smoking (if you smoke please indicate number of packs per day): _____ # years: _____

Do you experience or have:	No	Yes	Date of Onset	Do you experience or have:	No	Yes	Date of Onset
MEN				**WOMEN**			
Lack of energy				Lack of energy			
Sleeplessness/restless				Sleeplessness/restless			
Exercise (what)				Exercise (what)			
Balding				Thinning hair/hair loss			
Weight gain/loss				Weight gain/loss			
Self examine				Get sick easily			
Lethargic during day				Lethargic during day			
Memory loss				Memory loss			
Low sex drive				Low sex drive			
Impotent				Vaginal dryness/burning			
Premature ejaculation				Yeast/urinary tract infections			
Sexual disfunction				Sexual disfunction			
Testicular pain				Discomfort/pain during sex			
Urinary tract infections				Fibrocystic breasts			
Yeast infections				Uncomfortably cold often			
Urethral discharge				Uncomfortably warm often			
Poor muscle mass				Regular/irregular menstruation			
Enlarged breast/nipple				Sexually active			
Low sperm count				Pre/Post menopause			
Sexually active				Date of last period			
Low AM temperatures				PMS			
Scars (where)				Pregnant			
Smoke (how much)				# of children & type of delivery			
Alcohol (how much)				Scars (where)			
Chronic pain				Chronic pain			

Do you experience or have:	No	Yes	Date of Onset	Do you experience or have:	No	Yes	Date of Onset
HEAD				**LOWER EXTREMITIES**			
Headaches (and type)				Cold toes or feet			
Blurry vision (and when)				Joint pain (where)			
Ringing in the ears (type)				Numbness (where)			
Dizziness (and when)				Numbing/tingling pain			
Sinus problems (and when)				Arthritis condition			
Itchy scalp/dandruff				**UPPER EXTREMITIES**			
Brittle hair/hair loss				Cold finger			
DENTAL				Joint pain			
TMJ pain or popping jaw				Numbness (where)			
Amalgam (silver fillings) - how many?				Arthritis			
If removed, when and by whom?				**CHEST**			
Tooth extractions (any problems?)				Dull/sharp pain			
Caps (gold or ceramic)				Tightness			
Root canals - how many?				Difficulty breathing			
Missing teeth				Angina			
Bridge work/braces				Other heart related problems			
Gum disease				**GI TRACT**			
NECK				Heartburn (when)			
Stiffness/pain/spasms				Diarrhea/constipation			
Limited range of motion				Hemorrhoids (type)			
Injuries				Food sensitivities			
Dull/sharp pain				Blood in stool			
Any past surgery				BMs (per day or week)			
BACK				Parasites			
Muscle spasms				**SKIN**			
Dull/sharp pain				Psoriasis			
Limited range of motion				Dermatitis			
Injuries/surgeries				Cosmetic surgery			
Chiropractic therapy				Blotches/redness			
Disc problems				Acne			
Deformities				Moles/warts			
Osteoporosis				Aging too fast?			

Do you experience or have:	No	Yes	Date of Onset	Do you experience or have:	No	Yes	Date of Onset
NAILS				Lifestyle			
Ridged/spotted/split				International travel (where)			
Brittle/slow growth				Participate in sports (type)			
Fungus							
EYES							
Blood-shot/dry/itchy				Use recreational drugs (list)			
Pain/burning/yellow							
Glaucoma				Hetero/Homosexual (circle one)			
Cataracts				Past sexual abuse			
NOSE				Ever exposed to toxic chemicals?			
Dry/burn/bleed				Water (tap/filtered/bottled/distilled)			
Congested				Know family history?			
Snoring				Raised (where)			
THROAT/TONGUE				Deformities			
Hoarse/dry throat				Auto-Immune disorder (what)			
Phlegm				Are you in a relationship?			
Coating on tongue				Rate from I-10 (10 being best)			
Marking on tongue				Typical breakfast:			
Split in tongue							
Chronic bad breath							
Metallic taste							
EARS				Typical lunch:			
Excessive wax							
Ringing							
Itching							
Ear tubes (ever and when)				Typical dinner:			
Injuries							
Hearing aid needed							
THYROID							
Thyroid medications				Snacks:			
Surgery							

FEMALE PATIENTS ONLY

Name _____ Date _____

Address _____

Blood Type: A B AB O (+) (-) Unsure? D.O.B. _____

Primary Physician _____ Specialist _____

PERSONAL HEALTH HISTORY

Last Mammogram _____ Implants? Explain _____

Last Pap smear _____ Type [ ] Thin Prep [ ] Wet Mount

Findings _____

MENSTRUAL CYCLE INFORMATION

Last menstrual cycle _____

[ ] Pre-Menstrual [ ] Post-Menstrual [ ] Peri-Menopausal [ ] Pregnant

Date of hysterectomy (if applicable) _____ [ ] Complete [ ] Partial, explain _____

Any recent injuries or accidents involving breast or reproductive organs [ ] No [ ] Yes

Explain _____

HISTORY

Any history of breast disease or cysts? [ ] No [ ] Yes, explain _____

Any history of thyroid dysfunction? [ ] No [ ] Yes, explain _____

Any history of cancer of any type? [ ] No [ ] Yes, explain _____

Any history of Fibrocystic Breast? [ ] No [ ] Yes, explain _____

Any bone spurs now or in the past? [ ] No [ ] Yes (explain): _____

Breast tender or swollen 2 weeks before period? [ ] No [ ] Yes, explain _____

OTHER:

PRACTITIONER'S USE ONLY

Differential _____

Diagnosis _____

Pulse _____ Tongue _____

Treatment Strategy _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE;
YOUR ANSWERS WILL DETERMINE HOW WEMAY PROCEED WITH YOUR CARE

1. What are the most significant measures which you have taken to date to improve your state of health?_____

_____

_____

2. When was the last time you felt the best physically, emotionally, and psychologically?

[ ] 3-6 months ago [ ] 1 year ago [ ] 5 years ago [ ] 10 years ago [ ] 20 years ago Actual Date _____

3. Diet: Please describe your diet (indicate all applicable choices):

[ ] Protein - High/Low [ ] Special diet, list _____

[ ] Fat - High/Low [ ] Use sugar or sweeteners, list _____

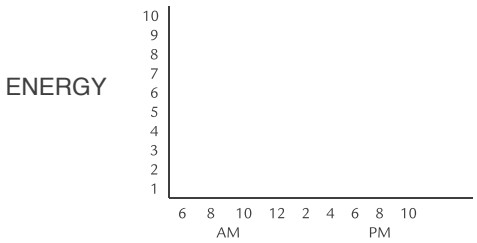
[ ] Carbs - High/Low [ ] Drink juices [ ] # meals per day _____

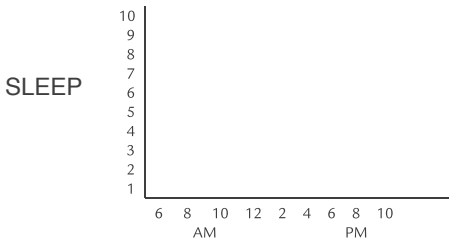
[ ] Crave salty foods [ ] Eat red meat [ ] Eat grains

[ ] Crave sweets/yeast foods [ ] Cholesterol (High/Med /Low) [ ] Snacks, list _____

[ ] Coffee /Tea intake a day_____ [ ] Soft drinks / week _____ [ ] Been told to reduce fat

4. Please chart energy and sleep levels with 10 being the best:





5. Have you at any time in you life taken broad-spectrum antibiotics (or any antibiotics) for respiratory, urinary, ear or other infections?
[ ] No [ ] Yes

Have you taken any antibiotics for skin, acne, or anything else? [ ] No [ ] Yes, explain _____

_____

_____

6. Place in box who in the family had the following: (Mother)-M, (Father)-F, (Sibling)-S, (Grandmother)-GM, etc...

Allergies		Cancer		Diabetes		Osteoarthritis	
Osteoporosis		Asthma		Multiple Sclerosis		Muscular Dystrophy	
Mental Illness		Auto-Immune Disorder		Rheumatoid Arthritis		Heart Disease	
Psoriasis		Alzheimer's		Drug Abuse		Stroke	
ADD		Fatigue		Hepatitis		Thyroid Disease	
Candida		Epstein Barr Virus		STDs		Surgeries	

CHRONOLOGY OF YOUR HEALTH EVENTS: Please list, starting with the last time you felt well, any events, such as surgery, high stress events, dental work, child birth, accidents, hormonal changes, travel, immunizations, etc... Please take time to remember all events.

DATE	EVENT
Aug. '63	Dog died, lost job, broke arm, had all silver fillings removed, got married

SYMPTOM CHECKLIST

Patient Name _____

Patient Weight _____ Lab Test Date _____

Date Diet Started _____ Checklist Date _____

Medical Diagnosis (if any) _____

_____

_____

SYMPTOM POINT SCALE:
Use the point scale to rate your symptoms based on how you've been feeling over the past 30 days.

0 = never or almost never have the symptom

1 = occasionally have it, effect is not severe

2 = occasionally have it, effect is severe

3 = frequently have it, effect is not severe

4 = frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea & vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Stomach pains or cramps
___ Heart burn
___ Blood and/or mucous in stools
___ Total

EARS

___ Itchy ears
___ Ear aches, ear infections
___ Drainage from ear
___ Ringing in ears
___ Hearing loss
___ Reddening of ears
___ Total

EMOTIONS

___ Mood swings
___ Anxiety, fear, nervousness
___ Anger, irritability, aggressiveness
___ Argumentative
___ Frustrated, cries easily
___ Depression
___ Total

ENERGY

___ Apathy, lethargy
___ Attention deficit
___ Fatigue
___ Hyperactivity
___ Restlessness
___ Poor physical condition
___ Stuttering or stammering
___ Slurred speech
___ Total

EYES

___ Watery or itchy eyes
___ Red, swollen or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision
___ Total

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia, sleep disorder
___ Facial flushing
___ Total

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heart
___ Chest pain
___ Total

JOINTS & MUSCLES

___ Pains or aches in joints
___ Arthritis
___ Stiffness or limited movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
___ Swollen tender joints
___ Growing pains in legs
___ Total

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
___ Persistent cough
___ Wheezing
___ Total

MIND

___ Poor memory
___ Difficulty completing projects
___ Difficulty with mathematics
___ Underachiever
___ Poor/short attention span
___ Confusion
___ Easily distracted
___ Difficulty making decisions
___ Learning disabilities
___ Total

MOUTH & THROAT

___ Chronic coughing
___ Gagging, often clearing throat
___ Sore throat, hoarse, loss of voice
___ Swollen or discolored tongue, lips
___ Canker sores
___ Itching on roof of mouth
___ Total

NOSE

___ Stuffy nose
___ Chronically red, inflamed nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucous formation
___ Total

SKIN

___ Acne
___ Itching
___ Hives, rash, dry skin
___ Hair loss
___ Flushing or hot flashes
___ Total

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Total

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
___ Anal itching
___ Total

_____ GRAND TOTAL

NOTES

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