Please thoroughly fill out the following form to the best of your ability in order for us to guide you. Please return the completed form via email to homegrownhealers@gmail.com at least 48 hours prior to your booked appointment.

Each complaint should be described fully, e.g.,

1. Right from its onset to its subsequent development, treatment taken so far and response to the treatment.
2. Areas affected: location sensation, direction of spread, sequence of events.
3. Conditions that bring on the trouble/aggravate it paying attention to physical as well as emotional factors.
4. Factors that increase the trouble/afford relief.
5. Any other ailments experienced at the same time as the chief complaint for example perspiration/nausea/gas/sleeplessness/headache/pain.

Client’s Name:

Client’s Age:

Client’s Date of Birth (DOB):

**MEDICAL HISTORY**

Are you employed and working? If so, what do you do for a living and are you able to work full-time or only part-time?

Please list and describe your chief complaints (symptoms) in order of importance to you, how long you have had each symptom, and any associated trigger(s) for each symptom. (Example: ***Symptom***: Headaches; ***Onset:*** for 2 years since; ***Initial Trigger:*** childbirth; ***Acute Triggers:*** perfume and stressful situations)

Do you experience any other health issues, not mentioned above?

Have you experienced any other childhood or past health issues that are now resolved? If so, please list and describe health issue(s) and how long it has been resolved.

Please list, providing dates, any and all past or scheduled surgical/medical procedures, hospitalizations or other serious illnesses:

Are you experiencing any pain, stiffness or swelling and if so where?

Are you having any issue/difficulties at work, with family, or socially?

Do you or have you experienced any addictions including, but not limited to alcohol, marijuana, tobacco, street drugs, prescription drugs, food, coffee, etc?

Please list/describe the health of your mother and father:

Do you take any supplements or medications? Please list the supplements or medication, brand and dosage in the table below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Supplement**  | **Brand**  | **Dosage**  | **Times per day**  | **Notes**  |

If you are a current or past client of Anthony William, please list all supplements and diet recommended by him:

Please list any known allergies:

Please list any practitioners, healers, helpers, pets or therapies in which you are involved (examples include but are not limited to: reiki, massage, acupuncture, physical therapy, chiropractor, infrared sauna, homeopathy, naturopath, emotion code, etc.):

What role do exercise and sports play in your life?

What are your favorite foods, drinks, and snacks?

What are your favorite activities and are you currently able to participate in them?

Have you read any of the books by Anthony William? If so, which ones?

**REPRODUCTIVE HEALTH – (men please answer where applicable)**

Are your periods regular?

How many days is your flow?

Do you experience PMS symptoms? If so, please explain.

Are your periods painful or symptomatic? If so, please explain.

Do you use pads or tampons? Which brands?

Please describe your birth control history including if you have been on or are on birth control, how long, for what, and what kind:

Are you currently pregnant?

Please list all pregnancies and dates including any aborted pregnancies, miscarriages, still births, vaginal deliveries, or C-section deliveries:

How many children do you have? Please list their ages.

Are you having or have you had any infertility issues? Please describe.

Do you experience any pelvic pain? If so, please explain?

Do you experience any sexual difficulties such as but not limited to: low libido, difficulty achieving orgasm, painful intercourse, bleeding, leakage, etc.)

**BOWEL AND BLADDER HEALTH**

Do you experience any bowel issues such as but not limited to: constipation, diarrhea, gas, leakage?

How often do you have a bowel movement?

Do you experience any urinary issues such as but not limited to: incomplete void, leakage, frequency and/or nighttime frequency, urgency?

Do you experience or have you experienced vaginal or urinary infections? If so, please explain.

**SLEEP**

Do you sleep well at night? If not, please explain.

How many hours of sleep do you generally get at night?

Do you wake up at night and if so, how often and why?

Do you experience night sweats and/or temperature fluctuation at night?

Are you able to recall your dreams and if so, frequently and vividly?

Do you generally have good dreams or bad dreams?

Are you aware if you snore or not?

Are you aware if you experience teeth grinding at night?

Are you aware if you experience muscle twitches or jerks while falling asleep or while asleep?

Do you feel rested after a night’s sleep?

Are you able to nap during the middle of the day?