

# Free Your Potential

## PERSONAL HEALTH HISTORY

Name \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Mobile phone \_\_\_\_\_

GP's name \_\_\_\_\_ GP's phone or clinic \_\_\_\_\_

Are you consulting other health professionals? \_\_\_\_\_

How did you hear about us? (if referred please provide name) \_\_\_\_\_

. . . . .

Are you taking any medications? \_\_\_\_\_ (Please list medications and reasons for usage)

Are you taking any vitamins or dietary supplements? \_\_\_\_\_ (Please list supplements and reasons for usage)

Do you now, or have you had in the past...      NO      YES      Please provide details  
When? What? How often? Still occurring? Resolved?

History of heart problems, chest pain or stroke?			
Any chronic illness or condition?			
Dizziness episodes, loss of balance or consciousness?			
Had seizures (epilepsy or other)?			
Had a surgery or been hospitalized?			
A serious illness?			
History of breathing or lung problems or asthma?			
Foot/back/neck pain or problems?			
Diabetes or thyroid condition?			
Sleeping problems?			
Cigarette smoking habit?			
Alcohol or other substance addiction?			
Digestion or eating problems?			
Allergies or intolerances?			
Migraines or headaches?			
Anxiety or depression?			
Stress?			
Psychological problems?			
A neurological disorder?			
Are your pregnant?			
ANTYHING ELSE?			

Please state any past physical or emotional traumas or accidents, stating the event or context, and year or age:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that this information is complete and accurate to the best of my knowledge. I understand that I am responsible for my own wellbeing during the course of this or subsequent consultations and will voice my concerns should there are any. I understand that my healing process requires my participation and I am willing to contribute as needed.

Signature \_\_\_\_\_

Date \_\_\_\_\_

## GOAL/OUTCOME ASSESSMENT

Do you consider yourself **physically** healthy?\_\_\_\_\_ Why?

*Possible areas of improvement:*

Do you consider yourself **emotionally** healthy?\_\_\_\_\_ Why?

*Possible areas of improvement:*

Do you consider that your **eating/drinking habits** are fully supporting your wellbeing?\_\_\_\_\_ Why?

*Possible areas of improvement:*

What are your **expectations** from your consultations with me?

Name 3 or more **priority issues** you would like to work on:

- 1.
- 2.
- 3.

Name 3 or more priority **long term goals** where you would like to free your potential:

- 1.
- 2.
- 3.

Name 3 or more **short term objectives** where you may lack clarity, focus and action:

- 1.
- 2.
- 3.

**Progress benchmarks :**

Please name a few benchmarks you think we could use that would indicate the progress on your goals :  
(*that indicates how much a certain goal has been achieved or that a certain issue has decreased or disappeared*)