Hinterland Energetics

Health Questionnaire

Name: _____ DOB: _____

Email Address: _____

Phone Number: _____

About Your Heath:

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, which have resulted in poor health. During your session we will begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness (Birth – Age 5):

Lets begin at birth when you may have first damaged your nerve system, lost your wellness and began your journey to ill health.

Please circle Yes / No where applicable

Birth Process:		Client Comments:
Was the delivery long and/or difficult?	Yes / No	_____
Were forceps or suction used?	Yes / No	_____
Was the birth Cesarean?	Yes / No	_____
Breech / Cephalic?	Yes / No	_____

Do you know of any stressful situation that may have been present for your mother or father or both?

_____

_____

_____

Health Questionnaire

Have you been vaccinated? Yes / No

(as per schedule? or any extras you may have had for another purpose (ie. Travel)

_____

_____

Have you had surgery and organs

been removed or replaced? Yes / No _____

Do you have any scars or piercings? Yes / No _____

Sleeping habits? Yes / No _____

Trouble sleeping, wake up tired etc.

Sleeping posture: (please tick) Side ____ Stomach ____ Back ____

Did you / do you have occupational stress? Yes / No _____

What is your current employment? _____

Previous employment? _____

Do you travel? If so, where have you been? Yes / No

_____

Do you have any pets: Yes / No

_____

Do you have physical and/or mental stress? Yes / No

_____

Have you ever lived near factories/mines/

or mobile phone towers? Yes / No _____

Have you had contact with herbicides /

pesticides or lived near crop spraying? Yes / No _____

Any other trauma or problems? Yes / No

_____

Were there any stressful events that have caused an impact on your health and wellbeing? _____

_____

_____

Health Questionnaire

Present State of Health (Symptoms):

What is you r body telling you right now? What symptoms are you experiencing?

Please explain and describe what is happening in your body.

_____

_____

_____

When did this start? _____

What do you think the cause is? _____

_____

_____

What activities aggravate your condition? _____

_____

What lessens your condition? _____

_____

Is this condition interfering with: Work ____ Sleep ____ Routine ____ Other _____

What is this stopping you from doing?

_____

_____

_____

If this were to go away tomorrow, what would be different about your life?

_____

_____

_____

Are you living the life you would like to live?

_____

_____

_____

Health Questionnaire

On a scale of 1 to 10, how happy are you? 1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, how much stress is in your life? 1 2 3 4 5 6 7 8 9 10

How do you handle stress? _____

_____

Are you ready to make changes to your life in order to heal, even if these changes are inconvenient? _____

Any other symptoms you are experience: (please tick if applicable)

Neck Pain	Numbness in Fingers	Nervousness
Stiff Neck	Shoulder Pain	Tension & irritability
Headaches	Cold Feet / Hands	Fatigue / Sleep Problems
Dizziness	Loss of smell / taste	Depression
Fainting	Cold / Flu	Chronic Fatigue
Ears ring	Allergies	Pins & Needles Legs
Balance Loss	Pain in mid-spine	Pins & Needles Arms
Numb Toes	Cold Sweat	Weight Problems
Chest Pain	Hearing Problems	Anxiety
Fever	Lights bother eyes	Constipation / Diarrhea
Loss of Memory	Menstrual Pain	Shortness of Breath
Migraines	Stress	Difficulty Breathing
Thyroid Issues	Not Sleeping	Lower Back Pain
Sciatica	Fibromyalgia	Knee Pain
Hypersensitivity to	Concentration/ Learning Issues	Stomach / Digestive Problems

Are there any other issues that are not mentioned above?

Health Questionnaire

Do you get sugar cravings? Yes / No

Do you get urgent hunger? Yes / No

What is your daily intake of sugar? _____

Do you have any allergies? If yes, please expand on any reactions to food, environment or medications Yes / No

_____

Do you have any amalgam fillings? Yes / No

Do you have any metal implants? Yes / No

Do you have a clock radio next to your bed? Yes / No

Do you use an electric blanket? Yes / No

What are you looking to get out of your treatment series?

_____

_____

What is/was your relationship like with your mother?

_____

_____

_____

_____

What is/was your relationship like with your father?

_____

_____

_____

_____

Have you had any trauma or abuse in your life?

_____

_____

_____

Please let us know in a few paragraphs, how we can assist you and help you the most?

_____

_____

_____

_____

_____

_____

_____

_____

_____

By signing this form, I agree and consent to the healing work while I am on this program. I understand that with any healing process and work on my body, my symptoms may worsen before they get better. I understand this program is designed to assist the body with healing by helping to remove stressors.
I acknowledge that I ….

I have freely decide to undergo the recommended treatment ad hereby give my full consent to this treatment.

Client Name: _____

Signature of Client: _____Date: _____