Hopewood Holistic Health

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Providing services in holistic health education, advocacy & life coaching
Specialty programs in local &international workshops & retreats
Creating a Sense of Place; A Spirit of Hope

PERSONAL HEALTH PROFILE

"*If you are not ready to alter your way of life, you cannot be healed*"
Hippocrates

This Personal Health Profile was modified from many examples, particularly suggestions from Rosemary Galdstar's book, Herbal Healing for Women and her Home Study Course, The Science and Art of Herbalism of which the practitioner has completed and teaches. *Many thanks Rosemary, Namaste!*

A main premise of **Hopewood's** service is that *you are in control of your health* and that by honoring your body, the environment we live in and the community you surround yourself with, health can become the norm not dis ease.. It begins by education, by trusting and reaching out to the plant allies and resources surrounding us, honestly assessing our daily habits, our diets and our source of spirit and play. It is wise to choose the guidance, support and supervision of a skilled health care practitioner, hopefully holistic, and one with which you resonate. It is time for each of us to take control of and be responsible for our health, our lives, our good fortune as well as our role in preserving or enhancing the Nature's bounty.

By considering the following items and filling out this profile carefully and thoughtfully you will be one step closer to finding health and personal understanding. The next step will be to take *action* in a kind and methodical manner, preferable with the assistance of a team of supportive and skilled Holistic Health Care Practitioners.

Present Health Status: Check each column where symptoms apply and elaborate in the space provided if necessary. Please indicate with a (√) any experiences below that you *sometimes* experience; two checks (√√) for those which occur *often*; and use three checks (√√√) for those which are a *major* concern.

General

Cardiovascular

___High Blood Pressure ___Low Blood Pressure
___Pain in the Heart region ___History of Murmur
___Poor Circulation (cold, numb Hands, Feet)
___Fast Heart Rate ___Slow Heart Rate
___Previous heart attack ___Stroke
___Swelling feet, ankles and hands

Skin

___Boils ___Dryness
___Acne ___Splotchy
___Bruises ___Itchy
___Scaly ___Eruptions
___Varicose Veins

Muscles/Joints

___Backache/neck, upper or lower (circle)
___Broken Bones ___Torn ligaments
___Mobility Restriction (Where_____)
___Arthritis/Bursitis (Where_____)

Respiratory

___Chest Pain, Tightness
___Difficulty Breathing
___Cough ___Congestion
___Sinus Trouble____Asthma

Eyes, Ears, Nose/Throat

_____Ear Aches ___Tubes
___Eye Pain/Strain ___Dry_____Wet
___Failing Vision ___Itchy Eyes
___Hay Fever ___Sinus Infections
___Sore Throat ___Post Nasal Drip
___Tonsillitis ___Hearing Loss

Gastro/Intestinal

___Belching ___Gas
___Constipation
___Diarrhea ___Ulcers
___Liver Problems
___Abdominal Pain
___Indigestion
___Gall Stones_____IBS
___Colitis, IBS, Crones
(_____Which)

Genital/Urinary/Kidney

___Excessive Urination ___Water Retention
___Burning Urine ___Kidney Stones
___Lower Back Pain ___Prolapsed Uterus
___Enlarged Prostate ___Dark circles under eyes
___Itchy Ears/eyes ___Bladder Infections
___Herpes ___Candida
___HPV ___General Itching
___Premature Ejaculation ___Orgasm
___Cervical Dysphasia ___Uterine or Ovarian Cysts
___Fibroids (Type_____)
___Pelvic Pain ___Painful Intercourse
___Difficulty Conceiving ___Breast Pain
___Breast lumps ___Vaginal Infections
___Endometriosis ___STD's

General

___Diabetes ___Thyroid (low, high)
___Metabolism ___General Immune Response
___Anemia ___Cancer
___Headaches (Type_____
_____(How Often_____)
___Shortness of Breath ___General Fatigue/Exhaustion
___Aids ___Chronic Fatigue
___Fibromyalgia ___Other
___Allergies To What? _____
Any Medications? _____
_____
_____

_____Dental Health (Specify)_____

___Mental Illness (Please specify History, diagnosis, medication, concerns, tirggers)

_____

_____

_____

_____

Women:
Pregnancy History: List each pregnancy you have had, including miscarriages and abortions

Pregnancy Dates	**Miscarriage Dates**	**Abortions Dates**

Menopause:
___Hot Flashes ___Dramatic Mood Swings
___Vaginal Drying ___Osteoporosis/penia
___Break Through Bleeding ___ERT Therapy

Menses:
___Regular Periods How often _____
How long _____
___light ___heavy ___Tender Breasts
___Painful Periods ___Mood Swings ___Bloating
___Cravings

Contraceptive History: List all kind(s) you have used if any, for how long, reaction.

IUD	BC Pill or Patch
Rhythm	Mucous Method
Diaphragm	Astrological
Condoms	Chemical Spermicides
Other?	

Men:
History of Prostate Health or Concern
PSA findings

Please list any or medical treatments related to any of the above.

Please list any current medications relating to any of the above. Please list how long you have been on each one. (If you have current labs, nutritional, blood workups, cancer) please attach and send along.

Please list and date all surgeries and hospitalizations.
Type:

Please list any accidents (car, falls, etc.), when, where, outcomes?

If you have one, who is your attending physician? Quality healthcare is a collaborative venture!

Name:_____Phone: _____

Email: _____

I given permission to contact them for consultation _____ yes _____ no

Family History: Circle any significant family health history, please relate to which side, maternal, paternal and how many generations: Diabetes, Cancer, Cardiovascular or Heart Disease, Mental Illness, Asthma, Tuberculosis, Thyroid, Obesity, Gout. Other:

Maternal Side **Paternal Side diabetes**

General State of Emotion and Self Concept (Please answer the following questions).
Are you able to express your feelings and emotions?

Do you feel like you are being heard when you do? If not why, in what circumstance?

Are you satisfied with your job, family, school situation?

Is there an excess of stress in your life? Can you specify the source?

Are you lonely?

Do you like how you look? What would you change if you could?

Do you sleep well?

Do you dream? Do you remember you dreams?

If you are in a relationship are you satisfied?

Do you often feel anxious, nervous, exhausted or fatigued?

Do you wake up easily in the morning?

Do you have a satisfying circle of friends, family members?

Do you have pets?

Do you have a hobby, what is it? How often do you do it?

Which of these feelings dominate your life: joy, happiness, anger sadness, fear, sympathy, worry, depression, other?

Please Indicate approximate dates and describe the nature of any major events or traumatic experiences you have had in the past 7 (seven) years

Goals of Treatment:

Please list top three goals for requesting services from Hopewood.
1.

2.

3.

Modality of Services Preferred (if known):

Please list in order of interest

Lifestyle & Wellness Assessment_____
Dosha/Constitutional Assessment_____
Perceived Stress Scale____
BACH Flower Assessment
Emotional Release Technique
(Tapping)
Yoga Therapy
Face/Tongue/Nail/Iridology____
Integrated Body Alignment (IBA)/
Reiki and Energy Balancing____

Stress Management ___
Detox & Cleansing ___
Lifestyle Fitness _____
Nutrition _____
Pranassage ___
Breath and Meditation _____

Please write a general narrative describing yourself, your health and your philosophy of life.

Personal Health Journal:
Please keep a journal of what you eat, how you rest and your fitness activates f*or one week*. Please bring this along with copies of any pertinent medical tests or diagnosis you have had within the last year. Also bring a list of any supplements or medications you may be taking.