Harmony Health Inc.

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Information Sheet

Date_____

Name: (Last, First, Middle Initial) _____
Address:_____
City:_____ State:_____ Zip Code: _____
Telephone Number:_____ Work Number:_____
Cell Number:_____ Fax Number:_____
Email:_____
Date of Birth:_____ Age: _____ Sex: _____ Marital Status:_____
Occupation: _____Weight:_____ Height:_____
Referred By: _____

Health History:
Please list your top health concerns:

_____
_____
_____

Please list any previous surgeries or hospitalizations:

_____
_____
_____

Have you had any implants? Breast or other = Silicone or Saline (circle type)
If other, describe:

_____

Please list all current medications, vitamins and herbs that you are currently taking:

_____
_____
_____

Please list all drug allergies and reactions:

_____
_____
_____

Please list all past diagnoses, medical problems and illnesses:
_____
_____
_____
Please list medical problems that occur in your immediate family:
_____
_____
_____
Please list all dental work; including fillings, root canals, crowns & extractions:_____
_____

For Women:
Menstrual History Age of Onset_____ ☐Regular_ ☐Irregular_ Days of Flow___ Last Period _____ ☐Bloating__ ☐Cramping __
Have you ever been pregnant? Yes ☐☐☐☐☐☐ Number of Pregnancies____
Number of Children_____
Have you ever had any abnormal Pap smears or Mammograms? ☐☐Yes ☐☐No

For Men:
Do you have any difficulty urinating? ☐☐Yes ☐☐No
Do you have to get up in the evening to urinate? ☐☐Yes ☐☐No

For Children:
Immunizations:
_____
Birth Weight_____ List any birth complications: _____
List any health or developmental concerns:
_____
_____
List any health risks:
_____
_____

Do you snore? _____

Do you smoke? _____ How much? _____ How many years? _____

Do you drink alcohol? _____ How much? _____ How many years? _____

Has drinking ever affected your job or home? _____
Have you ever used street drugs? _____
What types? _____

SENSE OF WELL-BEING:

Are you generally pleased with your life?

_____

Do you have a sense of inner well-being and contentment?

_____

What life stresses concern you most?

_____

Are you interested in emotional release therapy?

_____

EMERGENCY INFORMATION:

Name:_____

Relationship: _____

Telephone Number:_____ Work Phone Number:_____

Address:_____

_____

Employer:_____

I UNDERSTAND THAT BIOENERGETIC ASSESSMENT IS FOR INVESTIGATIONAL USE ONLY; IT IS NOT MEANT FOR DIAGNOSIS OR TREATMENT PURPOSES. I AGREE PRODUCTS PURCHASED MAY BE RETURNED WITHIN 90 DAYS OF PURCHASE FOR CREDIT OR REFUND AND ONLY IF PRODUCT SEALS ARE UNOPENED; ALSO THAT ALL SERVICES RENDERED ARE NONREFUNDABLE.

SIGNATURE_____