Vital Health of Woodstock

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Patient Health Appraisal

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY

IMPORTANT: The information requested in this form is of vital importance in determining the cause and correction of your health problem. Please write neatly and be as accurate as possible.

Read each question carefully, and score only those statements that pertain to you. If a question does not apply to you, leave it blank. If you have a doubt about a question or wish to clarify an answer you may use the back of this page.

Name _____ DOB_____ Age_____ Gender_____

Address_____ City_____ State_____ Zip _____

Email _____ Phone _____ Marital Status S M D W # Children?____

Occupation_____ Employer_____

Years Employed _____ Work Phone_____

Spouse's Name _____ Spouse's Employer_____

Spouse's Phone_____

Who referred you?_____ Past Nutritional Care? ☐ Yes ☐ No When?_____

YOUR MAJOR REASON FOR SEEING LAINY:_____

_____

Have you been treated for this problem? ☐ Yes ☐ No By whom?_____

What did they do or recommend?_____

When did your symptoms appear?_____ Is the condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure

Is it consistent or does it come and go?_____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are difficult to perform_____

How do you sleep? _____ hours/night ☐ Back ☐ Side ☐ Stomach Do you exercise? ____ hours/week

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CONDITIONS Check conditions you have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough

MEDICATIONS you are currently taking (including birth control)_____

_____

VITAMINS/HERBS/MINERALS/SUPPLEMENTS

you are currently taking_____

_____

you have previously tried _____

_____

Allergies_____

Pharmacy Name_____ Phone_____

OPERATIONS AND PROCEDURES

	Date		Date		Date
☐ Vaccinations	_____	☐ Tubes in Ears	_____	☐ Sinus	_____
☐ Tonsillectomy	_____	☐ Appendectomy	_____	☐ Hernia	_____
☐ Gall Bladder	_____	☐ Female Organs	_____	☐ Thyroid	_____
☐ Back Operation	_____	☐ Rectal Surgery	_____	☐ Stomach	_____

☐ Other (_____) _____

☐ I have never had any surgeries or operations.

Please check the health areas that affect you, then score the severity of symptoms for each using the scale 1 (mild) to 5 (very severe). Use the space provided to describe your symptoms in that area listing frequency where appropriate.

GENERAL	Rating	Description
☐ Overweight	_____	_____
☐ Underweight	_____	_____
☐ Exercise	_____	_____
☐ Smoking	_____	_____
☐ Drinking Alcohol	_____	_____
☐ Recreational Drugs	_____	_____
☐ Chemical Exposure	_____	_____
☐ Drinking Water	_____	_____
☐ Sexual Concerns	_____	_____
☐ Dizziness	_____	_____
☐ Rapid Heart Rate	_____	_____
☐ Heart Skipping Beats	_____	_____
☐ Blood Pressure	_____	_____
☐ Circulation	_____	_____
☐ Thirstiness	_____	_____
☐ Tired	_____	_____
☐ Epilepsy	_____	_____
☐ Motion Sickness	_____	_____
☐ Eye Condition	_____	_____

Please check the health areas that affect you, then score the severity of symptoms for each using the scale 1 (mild) to 5 (very severe). Use the space provided to describe your symptoms in that area listing frequency where appropriate.

SKIN	Rating	Description
☐ Teenage Acne	_____	_____
☐ Middleage Acne	_____	_____
☐ Unhealthy Skin	_____	_____
☐ Oily Skin	_____	_____
☐ Dry Skin	_____	_____
☐ Itchy Skin	_____	_____
☐ Eczema	_____	_____
☐ Psoriasis	_____	_____
☐ Cracking Skin	_____	_____
☐ Cysts	_____	_____
☐ Moles, Liver Spots	_____	_____
☐ Sun Damage	_____	_____
☐ Warts	_____	_____
☐ Fungus	_____	_____
☐ Rashes	_____	_____
☐ Herpes, Shingles	_____	_____
☐ Slow Healing Sores	_____	_____
☐ Bruise Easily	_____	_____
☐ Other	_____	_____
IMMUNE SYSTEM		
☐ Food Allergies	_____	_____
☐ Chemical Sensitivity	_____	_____
☐ Hay Fever	_____	_____
☐ Asthma	_____	_____
☐ Emphysema	_____	_____
☐ Frequent Colds/Flu	_____	_____
☐ Swollen Glands	_____	_____
☐ Sore Throats	_____	_____
☐ Laryngitis	_____	_____
☐ Cough	_____	_____
☐ Chest Congestion	_____	_____
☐ Post Nasal Drip	_____	_____
☐ Sinusitis	_____	_____
☐ Stuffy Nose	_____	_____
☐ Phlegm Expulsion	_____	_____
☐ Earaches	_____	_____
☐ Exhaustion/Weakness	_____	_____
☐ Hunger Related Fatigue	_____	_____

Please check the health areas that affect you, then score the severity of symptoms for each using the scale 1 (mild) to 5 (very severe). Use the space provided to describe your symptoms in that area listing frequency where appropriate.

	Rating	Description
☐ Shaking from Hunger	_____	_____
☐ Poor Concentration	_____	_____
☐ Cravings	_____	_____
☐ Memory Loss	_____	_____
☐ Confusion	_____	_____
☐ Other	_____	_____

DIGESTION

☐ Stomach Ulcers	_____	_____
☐ Liver Disease	_____	_____
☐ Gallbladder Disease	_____	_____
☐ Diabetes	_____	_____
☐ Lightheaded	_____	_____
☐ Unusual Hunger	_____	_____
☐ Nervous Eating	_____	_____
☐ Dark/Tarry/Bloody Stool	_____	_____
☐ Constipation	_____	_____
☐ Colitis	_____	_____
☐ Diarrhea	_____	_____
☐ Indigestion	_____	_____
☐ Gas/Bloat	_____	_____
☐ Heartburn	_____	_____
☐ Hemorrhoids	_____	_____
☐ Fissures/Polyps	_____	_____
☐ Intestinal Worms	_____	_____
☐ Gout	_____	_____
☐ Nausea	_____	_____
☐ Other	_____	_____

NEURO MUSCULAR SKELETAL

☐ Rheumatoid Arthritis	_____	_____
☐ Numbness Tingling	_____	_____
☐ Back Pain	_____	_____
☐ Spinal Curvature	_____	_____
☐ Muscle Spasms	_____	_____
☐ Sore Muscles	_____	_____
☐ Muscle Weakness	_____	_____
☐ Joint Stiffness	_____	_____
☐ Sciatica	_____	_____
☐ Sinus Headache	_____	_____

Please check the health areas that affect you, then score the severity of symptoms for each using the scale 1 (mild) to 5 (very severe). Use the space provided to describe your symptoms in that area listing frequency where appropriate.

	Rating	Description
☐ Migraines	_____	_____
☐ Physical Injuries	_____	_____
☐ Jaw Problems	_____	_____
☐ Other	_____	_____

REPRODUCTIVE (MEN)

☐ Prostate Problems	_____	_____
☐ Impotence	_____	_____
☐ Low Libido	_____	_____
☐ Other	_____	_____

REPRODUCTIVE (WOMEN)

☐ Painful Intercourse	_____	_____
☐ Low Libido	_____	_____
☐ Retaining Fluid	_____	_____
☐ Yeast Infections	_____	_____
☐ Fertility Concerns	_____	_____
☐ Pregnant	_____	_____
☐ Miscarriage	_____	_____
☐ Morning Sickness	_____	_____
☐ Menopause	_____	_____
☐ Premenstrual Illness	_____	_____
☐ Premenstrual Depression	_____	_____
☐ Discharge	_____	_____
☐ Breast Cysts/Lumps	_____	_____
☐ Mastitis	_____	_____
☐ Appetite Concerns	_____	_____
☐ Other	_____	_____

URINARY

☐ Frequent Urination	_____	_____
☐ Painful Urination	_____	_____
☐ Bed Wetting	_____	_____
☐ Bladder Control	_____	_____
☐ Kidney Infection	_____	_____
☐ Bladder Infection	_____	_____
☐ Kidney Stones	_____	_____
☐ Other	_____	_____

CHILDREN

☐ Colic	_____	_____
☐ Swollen Tonsils	_____	_____
☐ Learning Disability	_____	_____

Please check the health areas that affect you, then score the severity of symptoms for each using the scale 1 (mild) to 5 (very severe). Use the space provided to describe your symptoms in that area listing frequency where appropriate.

	Rating	Description
☐ Hyperactivity	_____	_____
☐ Teething	_____	_____
☐ Other	_____	_____

BEHAVIORAL

☐ Anxiety/Nerviousness	_____	_____
☐ Phobias	_____	_____
☐ Depression	_____	_____
☐ Manic Episodes	_____	_____
☐ Personality Shifts	_____	_____
☐ Trauma	_____	_____
☐ Greif	_____	_____
☐ Guilt	_____	_____
☐ Insomnia	_____	_____
☐ Stress	_____	_____

Confidential Information: Please write any additional information that you feel is important for us to know about you in order to provide the highest quality care._____

_____

_____

FAMILY HISTORY Report all major health problems for your immediate family.

Name	Relationship	Major Health Problem(s)
_____	_____	_____
		_____
_____	_____	_____
		_____
_____	_____	_____
		_____
_____	_____	_____
		_____
_____	_____	_____
		_____

The information I have provided is, to the best of my knowledge, accurate and true.

_____
Date

_____ _____
Patient Signature Signature of Parent of Guardian (if under 18)

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

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NOTICE OF PRIVACY PRACTICES

The Privacy Rule, also known as the Standards for Privacy of Individually Identifiable Health Information was instituted by the Department of Health and Human Services. This rule became effective April 2001 and is still in the process of modification.

The Privacy Rule provides the first comprehensive federal protection for privacy health information.

We, as most health care providers, are in the process of learning and implementing these new requirements. Please be aware that we have a two page summary which describes how medical information about you may be used. This information is available for you to have and read with care. We ask that you sign below to acknowledge that you are aware of these new privacy policies and that information is available to you.

_____
Date

_____
Patient Signature

_____
Signature of Parent or Guardian (if under 18)

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Please read, initial, and sign the statement below:

STATEMENT

It should be understood and agreed that Lainy Reicher is not a physician and that counsel given is restricted to the correction of nutritional deficiencies and is in no way intended to diagnose or treat a disease or medical disorder. References to specific body functions or organs during the course of counseling are not intended to diagnose disease or a medical disorder in that body function or organs, but to clarify the effects of nutritional deficiency on that body function or organs.

_____(initial)

I the undersigned, hereby give my voluntary consent for the administration of **Vital Health of Woodstock Deva Magic Ltd.**

_____(initial)

I understand that not all services provided a this office are recognized by the conventional medical establishment. I understand that research about holistic methods is ongoing as is research for conventional medicine.

_____(initial)

I am aware that there are risks in accepting service of any kind whether conventional or holistic, and I accept responsibility for those risks.

_____(initial)

I understand that there are no guarantees through the use of any service that I might choose to receive.

_____(initial)

I hereby release and discharge the practitioner **Lainy Reicher** from any and all liability or claims resulting from any service that I may receive while under the supervision of her care.

_____(initial)

I understand that **Lainy Reicher** maintains strict confidentiality of all information of her clients. I have read and understand the above statement.

_____
Date

_____
Patient Signature

_____
Signature of Parent or Guardian (if under 18)

_____
Witness