core healing llc
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First Initial and Last Name

You and Your Family's History

Please indicate if you, or a blood relative have had any of the conditons listed.

Self	Relative	Condition
○	○	Aids/HIV
○	○	Alcoholism
○	○	Allergies
○	○	Anemia
○	○	Arthritis/Rheumatism
○	○	Asthma
○	○	Auto Immune Disease
○	○	what types?
○	○	Bleeding Tendency
○	○	Cancer
○	○	Congenital Heart Disease
○	○	Diabetes
○	○	Goiter
○	○	Heart Disease
○	○	Hepatitis
○	○	Herpes
○	○	High Blood Pressure/Hypertension
○	○	Other?

Self	Relative	Condition
○	○	Kidney Disease
○	○	Leukemia
○	○	Mental Illness
○	○	Macular Degeneration
○	○	Migraine/Headaches
○	○	Mononucleosis
○	○	Nervous Breakdown
○	○	Obesity
○	○	Osteoporosis
○	○	Rheumatic Fever
○	○	Seizures
○	○	Sexually Transmitted Diseases
○	○	Stroke
○	○	Suicide attempts, thoughts
○	○	Thyroid Disease
○	○	Tuberculosis
○	○	Ulcers

Your Health History (General Symptoms)

Please indicate whether you are experiencing the symptoms listed currently (C), or in the past (P).

General Health

○	C	P	I tend to catch colds, other illnesses
○	C	P	I often have headaches
○	C	P	Other:

Energy

○	C	P	I feel tired or weak, lack energy
○	C	P	sudden energy drop time: ___ am/pm
○	C	P	post meal drop

Thirst

○	C	P	I'm frequenty thirsty
○	C	P	almost never thirsty
○	C	P	dry mouth
○	C	P	prefer cold drinks
○	C	P	prefer room temperature drinks
○	C	P	prefer hot drinks

Temperature

○	C	P	tend to be chilly
○	C	P	tend to be hot
○	C	P	experience hot flashes
○	C	P	cold weather bothers me
○	C	P	hot weather bothers me

Perspiration

○	C	P	too easily
○	C	P	too little
○	C	P	profuse sweating
○	C	P	frequent Sweating
○	C	P	night sweats
○	C	P	feet sweating
○	C	P	hand sweating
○	C	P	absence of sweating