The Body Temple Institute

HEALING STRATEGY COUNCILING

With Mama Mawusi Ashshakir

Detailed Client History Form

Name_____ Date of Birth _____
Age _____ Blood Type _____ Weight _____

Contact Phone Numbers:
_____
_____ Do You Have Any Allergies or sensitivities?
_____
_____
Who Is Your Medical Health Care
Provider?_____

Your Health Your Body

What is your **primary physical concern** or main reason for this consultation today?
_____

_____
_____

When did your symptoms start?
_____
Describe your symptoms: What seems to make it better? What makes it worse?
_____

Are there related symptoms?
_____
_____
List in order of importance other **physical problems/concerns** that are troubling you
(What do you feel/think is causing your health concern(s)?):
1. _____
   since:_____ causes*: _____
2. _____
   since:_____ causes*: _____
3. _____
   since:_____ causes*: _____
4._____
   since:_____ causes*: _____

State of Health

Family History

Back pain	Neck Pain	Headaches
Slip Disc	Should Pain	Joint Aches
Cancer	Fibromyalgia	MS
Diabetes	Arthritis	Gout
Reduced Mobility	Scoliosis	Cancer
Bone Fracture	Asthma	High Blood Pressure
Varicose Veins	Mental Illness	Fibroids
Stroke	Lymphedema	Obesity

Other_____

PERSONAL HABITS & HISTORY

Diet: vegan (no meat) Vegetarian (no red meat) Raw Foods Whole Foods (no packaged foods)

Any weight concerns?

How many meals do you have/day? Do you skip meals?

Do you have any complaints with your **digestion**?

How is your **sleep**? Difficulty falling asleep? Waking in the night?
How many hours of sleep do you get each night?
Are your sleep habits regular?

What's your **energy** level (1-10; 10=high)?

Do you **meditate** or use **relaxation** exercise? How often? ____ _

Is there anything else you would like to share?_____
_____
_____

How would you describe your general state of physical health? Excellent good fair poor
When do you last remember feeling really great? _____

Are you currently under the care of any **Natural health practitioners**? Reason:
_____
What type?
____*Chiropractor Acupuncturist Massage therapist*
____Physiotherapist Counselor Psychotherapist
____Homeopath
____Medical Doctor
____Dentist
Other: ___

DRUG/MEDICAL HISTORY

Date of last physical: _____

Have you had any accidents, conditions, illnesses, injuries, surgeries or hospitalizations which affected your health in such a manner that you've **never** been totally **well since**? **Y/N** If so, please list the type of condition and the approximate date it occurred.
_____
_____
Please list any other **medication(s**) you're taking and the condition(s) it's for: _____

_____

_____

List vitamins/minerals/**supplements**/herbs/remedies you're taking, amount(s), and reason:
_____
_____
_____
_____
_____

Do you drink alcohol? Yes or No
Do you Drink alcohol: (circle all that apply)
Daily, Weekly, Occasionally
Do you smoke ? Yes or No
How often?
Daily, Weekly, Occasionally

How often do you exercise? _____

Informed Consent For Care

I understand that:

1. No medical diagnosis will be given.
2. There is no promise of cure being made.
3. Mawusi Ashshakir is not a Medical Physician
4. All Natural health suggestions are taken on a voluntary basis
5. Client takes full responsibility for his or her course of action and the research to validate their health journey.

_____

Client Signature/Date