Hopewood Holistic Health

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Providing services in holistic health care, advocacy & life coaching including 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!*

One of the main premises of Hopewood's services 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. It begins by education, by trusting and reaching out to the plant allies and resources surrounding us, 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 for the earth and its' 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
___ Eye Pain/Strain
___ Failing Vision
___ Hay Fever
___ Sore Throat
___ Tonsillitis
___ Tubes
___ Dry ___ Wet
___ Itchy Eyes
___ Sinus Infections
___ Post Nasal Drip
___ 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
___ Burning Urine
___ Lower Back Pain
___ Enlarged Prostate
___ Itchy Ears/eyes
___ Herpes
___ HPV
___ Premature Ejaculation
___ Cervical Dysphasia
___ Fibroids (Type_____)
___ Pelvic Pain
___ Difficulty Conceiving
___ Breast lumps
___ Endometriosis
___ Water Retention
___ Kidney Stones
___ Prolapsed Uterus
___ Dark circles under eyes
___ Bladder Infections
___ Candida
___General Itching
___Orgasm
___ Uterine or Ovarian Cysts
___ Painful Intercourse
___ Breast Pain
___ Vaginal Infections
___STD's

General

___ Diabetes
___ Metabolism
___ Anemia
___ Headaches (Type _____, How Often _____)
___ Shortness of Breath
___ Aids
___ Fibromyalgia
___ Allergies To What? _____
Any Medications? _____
_____
_____
___ Thyroid (low, high)
___ General Immune Response
___ Cancer
___ General Fatigue/Exhaustion
___ Chronic Fatigue
___ Other

____ Dental Health (Specify)_____

___ Mental Illness (Please specify _____)

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?

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
heart disease
leukemia

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 your 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):

Anything that works
Please list in order of interest

Lifestyle & Wellness Assessment ___

Dosha/Constitutional Assessment ___

Perceived Stress Scale ___

BACH Flower Assessment ___

Emotional Release ___

Yoga Therapy ___

Face/Tongue/Nail/Iridology___

Integrated Body Alignment (IBA)/Pranassage ___

Reiki and Energy Balancing ___

Stress Management ___

Detox & Cleansing ___

Lifestyle Fitness ___

Whole Food Cooking and Recipes ___

Other _____

Breath and Meditation ___

Please write any 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 for 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.