Getting to the root cause. Sano Wellness Center	Name Date
	Birthdate / / Age Height Weight Gender M / F
	Address
	Email Phone
	Status (check all that apply): ( ) Child ( ) Single ( ) Married ( ) Widowed ( ) Divorced

How did you hear about us? _____

Employer name and address: _____

What is your occupation? _____

Your Health Profile; Why These Forms Are Important

As a naturopathic wellness approach, our goals are to first address the issues that brought you to this office and to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical, psychological and emotional stresses that can accumulate and result in serious loss of health potential. Generally the effects are gradual and may not even be felt until they become serious.

Answering the following questions will give us a profile of the specific stresses, past and present, that you face and allow us to better assess the challenges to your health potential.

HIPPAA Acknowledgement of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Sano Consulting's Notice of Privacy Practices. Sano is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request. Signing below acknowledges that you have access to this notice via internet or the copy in our office for your review at any time.

Name:	Signature/Guardian:	Date:

Goals For My Care: People see health care practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, others to correct core malfunctions.Your practitioner will weigh your needs and desires when recommending your program of care.

( ) Relief Care (symptomatic relief of pain/discomfort)
( ) Corrective Care (correcting/relieving cause of problem/symptoms)
( ) Comprehensive Care (address entire system bringing body to highest state of health possible)

Other Goals: ( ) Weight Loss ( ) Increased energy ( ) Hormone balance ( ) Other _____

List Health Concerns According to Severity: Rate 1-Mild to 10-Worst Imaginable					
Health Concern	Severity	When did the episode start?	Have you had this before? When?	Begin with injury/trauma/event?	Constant or Intermittent?

Other professionals seen for above condition(s): ( ) MD ( ) ND ( ) Chiropractor ( ) Homeopath ( ) Other _____

Diagnosis made: _____ **Treatment received:** _____

List all prescription drugs, over-the-counter-drugs and supplements you are currently taking:			
Drug/Supplement Name	Date Began	Purpose	Dosage/Quantity

BIRTH TO 17 YEARS	YES	NO	UNSURE
Complications at birth and/or adopted? Describe:			
Serious childhood illness or falls? Describe:			
Did you play youth sports? List:			
Prolonged use of medicine (e.g., antibiotics, inhaler, etc)? List:			
Were you under chiropractic care?			

18 YEARS TO PRESENT	YES	NO	N/A
Contraception/IUD? Describe:			
Pregnant? Due date:			
Sensitivity or allergy to fragrances or oils?			
Do/did you consume alcohol or drugs more than socially? If yes, how much/day?			
Do you play adult sports? List:			
Do you have a pacemaker?			
Do you have any metal in your body? Describe:			

VACCINATIONS/INJECTIONS - BIRTH TO PRESENT
TYPE: ( ) None ( ) Childhood, List: ( ) Flu ( ) Tetanus ( ) HPV ( ) Other: ( ) C19 mRNA: Pfizer, Moderna, J&J, AstraZ ( ) C19 Boosters, Qty:
REACTIONS:

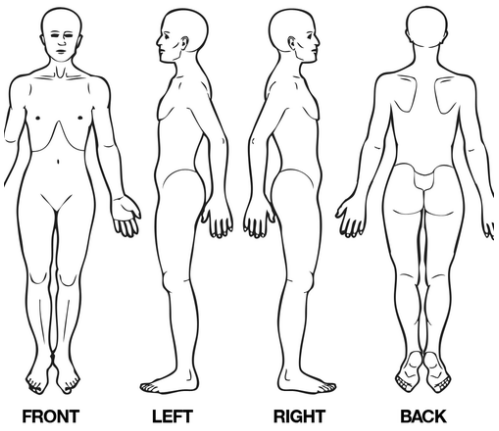
LIST TOP 3 STRESSES IN EACH CATEGORY		
Physical Stress: (e.g., sitting, lifting, poor posture, orthodontics, heel lifts, jaw splint, etc.)		
1.	2.	3.
Bio-Chemical Stress: (e.g., smoke, unhealthy foods, missed meals, drugs/pharmaceuticals, not enough water, etc.)		
1.	2.	3.
Psychological Stress: (e.g., work, relationships, finances, self-esteem, etc.)		
1.	2.	3.
Spiritual Stress: (e.g., crisis of values, meaning, and purpose; joyless or misalignment of core spiritual beliefs)		
1.	2.	3.
Emotional Stress: (e.g., feelings, mood, etc.)		
1.	2.	3.

Accidents, injuries, surgeries, X-rays, trauma, procedures, hospitalizations.	Date

Optional: Share Faith Story / Experience

ADVERSE CHILDHOOD EXPERIENCE (A.C.E.) The questions below cover all ten types of A.C.E.'s and refer to the years prior to your 18th birthday. (www.nikigratrix.com)	YES
Did a parent or other adult in the household swear at you, insult you, put you down, humiliate you or act in a way that made you afraid you might be physically hurt?	
Did a parent or other adult in the household push, grab, slap or throw something at you? Or ever hit you so hard you had marks or were injured?	
Did an adult or person at least 5 years older than you ever touch or fondle you? Ever had you touch or fondle their body in a sexual way? Attempt to or actually have oral, anal or vaginal intercourse with you?	
Did you feel that no one in your family loved you or thought you were important or special? Your family didn't look out for each other, feel close to each other or support each other?	
Did you feel that you didn't have enough to eat, had to wear dirty clothes and had no one to protect you? Your parents were too drunk or high to take care of you or take you to the doctor if needed?	
Were your parents ever divorced or separated?	
Was your mother or stepmother pushed, grabbed, slapped or had something thrown at her? Kicked, bitten, hit with a fist or with something hard? Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	
Did you live with anyone who was a problem drinker or alcoholic? Or who used street drugs or abused prescription drugs?	
Was a household member depressed or mentally ill? Did a household member attempt suicide?	
Did a household member go to prison?	
Were you bullied, taunted or shunned at school?	
Did you experience racism or homophobia or similar forms of hate abuse?	
Did you experience a serious physical trauma, illness or accident in childhood which required hospitalization?	
Did you experience a difficult or traumatic birth?	
Did you witness violence or abuse of a sibling, parent or family member?	
Did an important family member or caregiver die during your childhood?	
Did you experience homelessness during childhood?	
Did your family experience significant adverse financial events during your childhood such as loss of job, financial stability or home?	
Was there significant trauma experienced by your mother during her pregnancy with you?	
Were your parents or grandparents affected by war, political upheaval or other adverse events listed above during their lifetime?	
Would your parents/caregivers rate high on this assessment?	

Check all that apply to you:									
☐	Traumatic birth	☐	Clumsy	☐	Listening issues	☐	Low self-esteem	☐	Ear infections/surgeries
☐	Picky eater	☐	Bedwetting	☐	Memory issues	☐	Negative disposition	☐	Emotional control (+ / -)
☐	Shyness	☐	Childhood trauma	☐	Sensory issues	☐	Phobias	☐	Addiction(s)
☐	Homework struggles	☐	Low confidence	☐	Travel sickness	☐	Messy	☐	Other:

HEALTH HISTORY INFORMATION: BODY AREA		Rare	Mild	Moderate	Severe
	Neck				
	Upper back				
	Lower back				
	Chest				
	Abdomen				
	Arms				
	Hands				
	Quads				
	Hamstrings				
	Calves				
	Feet				

PAIN	
Describe your pain if applicable: ( ) sharp ( ) dull ache ( ) stabbing	
Describe improvement since acquiring the pain: ( ) same ( ) improving ( ) worse	
Does the pain travel or radiate: ( ) yes ( ) no	Where?
What makes it better?	Worse?
Family history of this or a similar symptom? ( ) yes ( ) no	Who?
Condition interferes with: ( ) work ( ) leisure ( ) sleep ( ) sports/exercise ( ) attitude ( ) other	
Describe how so:	
Have you needed to make any "positive" changes as a result of this condition? (i.e., eat better, less alcohol/drugs, less destructive sports, pray, etc.) ( ) yes ( ) no	
Describe how so:	

CHECK ANY DISORDER YOU HAVE HAD IN THE LAST 5 YEARS									
	CARDIOVASCULAR		NERVOUS		VASCULAR		MUSCLES		OTHER
	Heart Disease		Chronic Pain/Sciatica		Osteoporosis		Muscular Tension		Infection/Rashes/Warts
	High Blood Pressure		Shingles/Herpes		Vertebral Disc Disorders		Spasms		Asthma/Sinus
	Blood Vessel Disorder		Spinal Cord Injuries		Arthritis (any type)		Cramps		Dizziness/Ear Ringing
	Varicose Veins		MS/Parkinson's		Sprains/Strains		Fibromyalgia		Headaches
	Bleeding Disorder		Cerebral Palsy		Tendonitis/Bursitis		Muscular Dystrophy		Digestive Discomfort
	Blood Clots		Numbness/Tingling		Carpal Tunnel		Jaw Pain/TMJ		Diabetes
	Stroke		Epilepsy		Scoliosis		Joint Stiffness		Cancer
	Cold Hands/Feet		Fatigue/Chronic Fatigue				Joint Swelling		PMS/Menopause

Comments: