Awakenings
Polarity
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PERSONAL HISTORY FORM

PRINT LEGIBLY! All information will be kept in the strictest confidence

Name: ______________________________ Today's Date: ____________

Address/City/State/Zip: ______________________________

Home Phone: ____________________ Cell Phone: ____________________

Email: ______________________________ Age:________ Sex: ________

Race: ________ Occupation: ______________________________

Highest Level of Education/Major: ______________________________

Date & Time of Birth (if you know time): ________________ Place of Birth: ____________

Marital Status: __________ Any Children? If so, number and ages ________________

Pets? ______________________________ Referred to us by: ________________

In case of emergency, call (name and phone number): ______________________________

Primary Health Care Provider(s) – list them all along with their specialty if any:

____

____

Primary Reasons for Making this Appointment: ______________________________

____

____

Current symptoms and/or diagnoses: ______________________________

____

When did symptom(s) start? ________________ What brought it on? ________________

Do symptoms go away and then reoccur, or are they constant? __ Intermittent __ Constant

Does this interfere with your" ___Work ___Sleep ___Relationships ___Exercise ___Diet

___Pleasure ___Other: ______________________________

What relieves it? ____________________ Worsens it? ____________________

What other therapies/treatments have you tried for this condition? ________________

____

Do/did they help? ______________________________

Recent or past injuries, surgeries, or significant illnesses ______________________________

____

Circle all that apply to you below and write year(s) beside it:

Depression	Grief	Pain	Fatigue	Headaches
Phlebitis	Digestive Issues	Heart/Vascular	TMJ	Reproductive Issues
Diabetes	Kidneys	Colitis	Cancer	PMS
Infection	Varicose Veins	Osteoporosis	Neurological Issues	Cholesterol
Fever	Spine	Blood Pressure	Allergies	Constipation
Muscular	Respiratory	Anxiety	Urinary	Glandular
Hearing	Liver	Gall Bladder	Diarrhea	Ulcers
Mood Swings	Muscle Tension	Vision	Fear	Nightmares
Epilepsy	Arthritis	Inflammation	Anemia	Resentment
Sense of Taste	Edema	Anger	Sinus	Phobias
Joints	Sports Injury	Other Accident: ______________________		

Life Experiences (circle all that apply and write year beside it):

Sexual Difficulty	Memory/Intellectual Difficulty	Birth/Death of Significant Other
Emotional abuse	Sexual abuse	Physical abuse
Alcohol/Drug abuse	Loss/Change of Job	Loss/Change of Home
Serious Family Illness	Addition or Change to Household	Other: ______________

How do the circled items above influence your daily life and activities: ______________________

____

____

How comfortable are you in your living situation? ______________________________

Current Emotional Status ______________________________

Current Stresses in Life ______________________________

Ways that you relax or relieve stress ______________________________

Food(s) you eat most often ______________________________

Foods you avoid ____

Typical Daily Menu ____

____

Exercise Routine ____

Sleep Pattern ____

Religious/Spiritual Practices ____

Other Significant Experiences or Circumstances affecting your well-being ____________________

____

Supports that you rely on (Emotional, Mental, Physical, Spiritual, Financial)

____

____

Substances Used	**What Type**	**How Much**	**How Often**
Alcohol			
Tranquilizers			
Sleeping Pills			
Marijuana			
Other Drugs			
Prescription Drugs			
Over The Counter Drugs			
Caffeine			
Nicotine			
Laxatives			
Sweeteners			
Nutritional Supplements			
Other			

CLIENT WAIVER

I, the undersigned, understand my Polarity Practitioner is representing AWAKENINGS POLARITY and that polarity therapy is done fully clothed. I also understand that I should be free of alcohol or illicit recreational drugs when scheduling a polarity therapy session. I understand that my practitioner is not a doctor and does not prescribe for or treat illnesses or conditions at any time. As the client, I take full responsibility for my own health care and realize that this service is not a substitute for medical care by a licensed physician.

Client Signature ______________________________ Date ______________