



JOHN FRANCIS
Spa

CONFIDENTIAL CONSULTATION

Name: _____ Age: _____
 Address: _____ D.O.B: ____ / ____ / ____
 City, State, Zip: _____
 Occupation: _____
 Phone: (Home) _____ (Cell) _____
 Email: _____ Referred by: _____

GENERAL HEALTH RECORD

Are you currently receiving care from any health professional? Yes/No If yes, please explain? _____

List and describe your major concerns	Date of onset
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

Do you have or have you had any of the following?

Y / N Anxiety	Y / N Asthma	Y / N Heart disease	Y / N High blood pressure
Y / N Varicose veins	Y / N Hepatitis	Y / N Seizures	Y / N Arthritis
Y / N Migraines	Y / N HIV	Y / N Diabetes	Y / N Thyroid Issues
Y / N Cancer, what kind? _____			
Y / N Other _____			

Accident and traumatic injury history: _____

Surgeries: _____

Current or recent medications: _____

Allergies: _____

MENSTRUATION

Please circle those that apply:

Y / N Are you pregnant?	Normal / Irregular / None	Around your period do you get:	Irritable	Cramps
Y / N Are you on the pill?	Light / Heavy	Headaches	Low back pain	Breast tenderness
Y / N Clots?	Perimenopause / Menopause	Other:	_____	

SELF-ASSESSMENT

Complete this portion by placing a 1, 2, or 3 next to the symptoms you currently experience. Leave the box empty if it doesn't apply to you at all. 1 = rarely 2 = sometimes 3 = always

<input type="checkbox"/> easily upset	<input type="checkbox"/> facial redness	<input type="checkbox"/> easily sigh	<input type="checkbox"/> dizziness
<input type="checkbox"/> headaches	<input type="checkbox"/> bitter taste in mouth	<input type="checkbox"/> pain in ribs	<input type="checkbox"/> numbness
<input type="checkbox"/> eye problem	<input type="checkbox"/> brittle nail	<input type="checkbox"/> twitching or spasm of muscle/s	<input type="checkbox"/> easily awaken
<input type="checkbox"/> chest pain	<input type="checkbox"/> palpitation	<input type="checkbox"/> excessive dreams	<input type="checkbox"/> night sweating
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> irregular heartbeat	<input type="checkbox"/> insomnia	<input type="checkbox"/> oversleeping
<input type="checkbox"/> low blood pressure	<input type="checkbox"/> cold hands & feet	<input type="checkbox"/> swelling of the hands/feet	<input type="checkbox"/> poor memory
<input type="checkbox"/> stomach pain	<input type="checkbox"/> flatulence	<input type="checkbox"/> heartburn	<input type="checkbox"/> over acids
<input type="checkbox"/> nausea	<input type="checkbox"/> vomiting	<input type="checkbox"/> indigestion	<input type="checkbox"/> belching
<input type="checkbox"/> foul breath	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> bruise easily	<input type="checkbox"/> fatigue
<input type="checkbox"/> constipation	<input type="checkbox"/> abdominal distension	<input type="checkbox"/> loose stool	<input type="checkbox"/> diarrhea
<input type="checkbox"/> thirsty	<input type="checkbox"/> abdominal pain & cramping		
<input type="checkbox"/> cough	<input type="checkbox"/> coughing blood	<input type="checkbox"/> bronchitis	<input type="checkbox"/> asthma
<input type="checkbox"/> pneumonia	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> loss of voice	<input type="checkbox"/> depression
<input type="checkbox"/> sinus problem	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> common cold	<input type="checkbox"/> phlegm
<input type="checkbox"/> sore throat	<input type="checkbox"/> spontaneous sweating	<input type="checkbox"/> skin problem	
<input type="checkbox"/> ear ringing	<input type="checkbox"/> hearing loss	<input type="checkbox"/> back pain	<input type="checkbox"/> knee pain
<input type="checkbox"/> joint pain	<input type="checkbox"/> hair loss	<input type="checkbox"/> fright	<input type="checkbox"/> impotence
<input type="checkbox"/> night urination	<input type="checkbox"/> edema	<input type="checkbox"/> urinary problem	<input type="checkbox"/> decreased sex drive

GENERAL LIFESTYLE INFORMATION

Special Diet	Y / N	If yes, please describe: _____
Soda	Y / N	If yes, how much/often: _____
Coffee/Caffeine	Y / N	If yes, how much/often: _____
Smoking	Y / N	If yes, how much/often: _____
Alcohol use	Y / N	If yes, how much/often: _____
Other drug use	Y / N	If yes, how much/often: _____
Exercise	Y / N	If yes, please describe: _____

Other relevant habits or things that relate to your physical and emotional health: _____

PLEASE READ AND ACKNOWLEDGE OUR 24 HOUR CANCELLATION POLICY

You are required to provide a Visa or Mastercard when you make your appointment. To avoid being charged for the full cost of your service, please notify us at least 24 hours prior to your appointment of any changes or cancellations.

Signature: _____ Date: _____ / _____ / _____