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

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