Last name:	First name:	Initial:
Date of Visit:	Date of birth:	Referred by:
Name of Parents or Guardians if under 18:		
Address:		
Suburb:	State:	Postcode:
Phone:	Work:	Mobile:
Email:	Website:	
Current Occupation:		
Past Occupations:		
Present Conditions/Symptoms:		
How did it Happen? When did it Happen? Why do you feel it Happened?		
Drugs: Do you take or have you taken any drugs for this or other conditions? (include prescriptions, oral contraceptives, Lifestyle drugs)		
Are you a smoker?	Have you been a smoker?	
Do yo have serious allergies and/or anaphylaxis to anything? If so, which ones?		
Women only- Are you pregnant?	Have you been diagnosed of any disease?	
Describe your present emotional state:		
Did you have any past emotional traumas that still affect/or affected your health?		
Past Medical History:		
Family History:		

Mónica Winston
HOLISTIC HEALING PROGRAMS

Please list everything you eat or dring in a typical day

Breakfast	Lunch	Dinner
Snacks		

Drinks	How many glasses per day
Water	
Coffe/Tea/Cola/Guarana etc	
Alcohol-Wine/Beer/Spirits etc	

Dietary supplements (Vitamins ,herbs, etc)

Product	Daily Amount

Excercise	Type	How much per day
Cardiovascular	Running	
	Swimming	
	Team Sports	
Strength Training		

Hobbies:
Past:
Present:

Relationships: (rate them accordingly-1 = Satisfyng 2=Bearable,3 = Strained 4 = Nonexistent

Spouse	Children	Parents	In-Laws
Relatives	Friends	Boss	Co-Workers
Stress- What causes your stress?			
Strength- What gives you strength?			
Sleeping Patterns			
What type of music do you listen to? Other relevant information			