Personal Health Record

Last Name , First _____ F M Tel Home _____

Address _____ _____ Tel Office _____

City _____ Postal Code _____ Tel. Cell. _____

Email _____ **Birth Date** **Y/M/D / / Age** _____

Occupation _____ Sitting ___ Standing ___ Repetitive ___ Refer By _____

Have you had & how many times? **Massage** Relaxing _____ Therapeutics _____ Trame____ Physio_____

Chiro _____ Osteo _____ Acupunture _____ Energetics_____ Others_____

Are you supervised by a physician, Yes __ Name? _ _____ **No**

Do you have at this time OR Did you had in the past **Health Problem** **NO___ Yes ___**

Circulation	Good	☐	Heart problem	☐	Low Pre	☐	High Pressure	☐	_____
Digestion	Good	☐	Slow ☐	Fast ☐	Liver, GB	☐	Stomach	☐	_____
Elimination	Good	☐	Urinate often	☐	Diarrhea	☐	Constipation	☐	_____
Respiration	Good	☐	Asthma ☐	Apnea ☐	Épilepsie	☐	Allergy	☐	_____

Diabetes___ Cholesterol___ Migraine___ Skin problems ___ Cold Feet ____ Cold Hands ____

Inflammation_____ Arthritis_____ Osteoarthritis_____ Cramps_____ Varioce veines_____

Surgery, Fracture Describe and **mention year** and if they are any aftermath _____

_____

_____

Do you have PAIN? ON 10 **1 = A Little** **10 = Intolerable** **R = Right side** **L = Left Side**

BACK - Upper R____ L____ Neck R___ L___ Scapula R___ L___ Middle R ____ L ____ Bottom R____ L ____ Hips R___ L ___

Thighs R ____ L ____ Knee R ____ L ____ Calf R ____ L ____ Ankle R____ L ____ Feet R____ L ____Toes R_____ L ____

Arm R___ L___ Shoulder R ___ L___ Elbow R___ L___ Forearm R___ L___ Wrist R___ L___ Fingers R_____ L_____

Belly, Ribs _____ Others _____

Do you take Medication, for what? _____

Have you ever done? What year? Anxiety _____ Burn-out_____ Depression _____ **NO ____**

What have you done so far to help your physical and psychological situation? Hobbies? Sports? Exercises? Frequency?

_____

_____

Appetite Normal ☐ little ☐ Big ☐ Salty ☐ Sweet ☐ Spicy ☐ Others _____

Number of hours sleep _____ Relaxing ☐ Cut Hours ☐ Always Tired ☐ _____

Children Girl Boy Glasses, lens ☐ Prostheses ☐ _____

Others informations that I should know ? No ___ Yes _____

I declare that all these informations are to my best knowledge O __ D __NLP__MER__ Coaching____

My actual condition allows me to receive holistic treatment.I also agree to let know any future change of condition

By giving my email, I consent to receive communications from ''Sylvie Soleil'' Bellemare and Centre Belle Vie

Signature _____ Date _____

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