

Full Spectrum Wellness

Enhancing Health and Harmony in the Body

CLIENT INFORMATION AND HEALTH HISTORY FORM

Practitioner Notes:

General Information:

Name: _____

Date: _____

Contact Phone: _____

Email: _____

Address: _____ City: _____ State: _____

Zip: _____

Date of Birth: _____.

Sex: F M Height: _____ Weight: _____

Relationship Status: Single: Married: Divorced: Widowed:

Emergency Contact Information:

Name: _____

Phone: _____

Relationship: _____

Birth History:

Were you born at home, in a hospital, or birthing center?

Were you born by vaginal delivery or c-section?

Did your mom have an epidural during your labor?

Yes No Unsure

Was there any pain medication administered during labor?

Yes No Unsure

Was the medication Pitocin used to induce labor?

Yes No Unsure

Were you adopted, raised by your biological parents, or other?

If other please explain:

Were you nursed or bottle fed?

Which state and country did you grow up in?

Dental History:

Do You Have Any of The Following?

		How Many? / Date(s) of Procedure(s)
Yes <input type="checkbox"/> No <input type="checkbox"/>	Root Canals	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Crowns	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Implants	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Dentures	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Braces	
Yes <input type="checkbox"/> No <input type="checkbox"/>	Mercury (Amalgam) Fillings	

Health History:

Health of Mom:

Health of Dad:

How many siblings do you have? _____ What Number Are You In Birth Order? _____

List Childhood Traumas:

List Adult Traumas:

Right or Left-Handed? R L | Are You Pregnant? Yes No | Due Date: _____

Number of Children and Their Ages:

Have you had any abortions: Yes No | How many? : _____

Have you had any miscarriages: Yes No | How many? : _____

Have you had any of your children die? : Yes No

Were Your Children Born By Vaginal Delivery Or C Section? : _____

Were There Any Medications Administered During Labor? : Yes No

If Yes, Please List Which Ones:

Did You Nurse, Or Are You Currently Nursing? : Yes No

Occupation: _____ Do You Enjoy Your Job? Yes No

Blood Type: _____ Have You Been Vaccinated? Yes No

If Yes, Provide the Date(s) For The Corresponding Vaccinations:

Flu Vaccine: _____

Shingles: _____

Gardasil: _____

Pfizer: _____

Astrazeneca: _____

Hn1: _____

Moderna: _____

Covid: _____

Which Of The Following Have You Lived Near?

Powerline(s): How Long and When: _____

Chemical Plant(s): How Long and When: _____

Airport: How Long And When: _____

Do You Have A Regular Bowel Movement Before Noon Each Day? Yes: No:

Two Or More Per Day?: Yes: No:

Constipated?: Yes No Diarrhea?: Yes No

Do You Feel Rested?: Yes No

How Much Sleep Do You Get Per Night? _____(hrs)

What Time Do You Normally Go To Bed? _____

Do You Wake Up in The Night?: Yes No Sometimes

What Time(s)? _____

How Often? _____

Do You Wake Up To Go To The Bathroom?: Yes No Sometimes

Do You Feel Stressed?: Yes No Sometimes

What Causes Most Of Your Stress?

What do you do when you are stressed?

Do you feel you have an outlet or a way to relieve stress, and what is it?

Describe Your Energy Level:

Do You Exercise?: Yes No

How often and what form of exercise?

Are you currently seeing a medical doctor for any reason?: Yes No

If Yes, Please Explain:

Please List any Surgeries you Have Had:

<i>Surgery</i>	<i>Month/Year</i>	<i>Purpose</i>

Are you Currently Taking Any Medication?

<i>Medication</i>	<i>Date Prescribed</i>	<i>Purpose</i>

Please List 5 Main Health Concerns You Have in Order of Importance

(1 Being Most Important; 5 Being Least Important)

1.

2.

3.

4.

5.

Have You Ever Been Diagnosed By A Medical Doctor Or Feel You May Have Any Of The Following? (Please List Month And Year.)

		<i>Explanation</i>	<i>Month/ Year</i>
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Adhd</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Aids/Hiv</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Alcoholism</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Allergies</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Anemia</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Appendicitis</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Arteriosclerosis</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Asthma</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Blood Pressure</i>		

Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Breathing Problems</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Bursitis</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Cancer</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Cholesterol</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Colitis</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Constipation</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Crohn's</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Depression</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Diabetes</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Diverticulitis</i>		

Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Diverticulosis</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Eczema</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Edema</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Emphysema</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Epilepsy</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Fibrocystic Breast Disease</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Fibromyalgia</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Fluid Retention</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Gallbladder</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Goiter</i>		

Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Gout</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Headaches/Migraines</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Heart Disease</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Hypoglycemia</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Influenza</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Joint Aches</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Kidney Problems</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Lyme</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Measles</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Multiple Sclerosis</i>		

Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Mumps</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Neuralgia</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Nervous Tension</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Night Sweats</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Numbness</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Pleurisy</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Penumonia</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Polio</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Rheumatic Fever</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Scarlet Fever</i>		

Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Skin Problems</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Stroke</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Thyroid</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Tuberculosis</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Ulcers</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Varicose Veins</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Venereal Disease</i>		
Yes <input type="checkbox"/> No <input type="checkbox"/>	<i>Whooping Cough</i>		

Yes <input type="checkbox"/>	Menopause		
No <input type="checkbox"/>			
Yes <input type="checkbox"/>	Menstrual Cramps		
No <input type="checkbox"/>			
Yes <input type="checkbox"/>	Miscarriage		
No <input type="checkbox"/>			
Yes <input type="checkbox"/>	Mood Swings		
No <input type="checkbox"/>			
Yes <input type="checkbox"/>	Premenstrual Syndrome		
No <input type="checkbox"/>			

Food and Beverage Consumption

*List The Three **Worst** Foods You Eat During The Average Week:*

1.

2.

3.

List The Three **Healthiest** Foods You Eat During The Average Week:

1.

2.

3.

Do You Smoke: Yes No | Times Per Day/Week: _____

Approximately How Much Water Do You Drink A Day? _____

Distilled: Reverse Osmosis: Spring: City Tap: Well:

How many of these beverages do you consume per day?

Coffee:

Sweet Tea:

Green Tea:

Energy Drinks:

Black Tea:

Bottled Juice:

Soda:

Herbal Tea:

Do You Use A Juicer? Yes No

If Yes: Vita Mix Or Extractor? _____ How many times per week? _____

How many alcoholic beverages do you consume per week?

What type of alcohol do you consume (beer, wine, etc.)?

How many times do you eat out per week?

How many times do you eat fish per week?

How many times do you eat raw nuts or seeds per week? _____

Please list any natural supplements you currently take, the purpose of the supplement, and the date you started taking it.

<i>Supplement</i>	<i>Purpose</i>	<i>Date</i>

How did you hear about Full Spectrum Wellness? _____

Please take time and use this page to tell me your story.

You may write on additional pages if necessary. Write whatever you think will help me understand where you are in your pursuit of wellness.

Preparation For Your Visit and The Spectravision Scan

The Spectra Vision will be evaluating the responses of the body to the various digital signals and their relationship to overall balance and energy flow. This process is called “BioEnergy Balancing” and is designed to assess impedances within the BioNet of the body. The BioNet is the electrical aspect of the body that lies within the connective tissues.

1. Please keep a three-day food log and bring it to your first appointment. Be honest and record everything you eat and drink.
2. Stop taking all supplements 24 hours before your visit. Continue prescriptions.
3. No alcohol or caffeine within 12 hours of testing.
4. Do not eat at least 2 hours before your appointment.
5. Make sure you are well hydrated by drinking $\frac{1}{2}$ your weight in ounces the day before, and the day of, your appointment. This is a good rule of thumb for everyday life.
6. No exercise the day of the appointment. Get a solid 8 hours of sleep. You should be well rested for your test.
7. Bring any supplements to your appointment that you take on a regular basis, so we can test them to see if they are keeping your body in balance.
8. A low-level laser will be used. Please do not wear black or dark clothing. Please wear a white or light-colored shirt to your appointment.

Contraindications

The Spectra Vision Will NOT Be Used If:

1. Subcutaneous TENS units – must be able to deactivate the unit so it doesn't interfere with the MC Scan or SC testing.
2. You are pregnant.
3. You have a pacemaker.
4. You have had an organ transplant and are on Immuno-Sup drugs.
5. You have seizures.
6. You have shunts or stints of any kind.
7. You have been electrocuted or struck by lightning.
8. It is okay if you have metal plates, pins, rods, and/or denture implants.

Disclaimer: *Dr. Allen's intention is to reeducate and assist with natural health information for the sole purpose of suggestion. You are responsible to research for yourself and choose the way you desire to live. This health history form is not intended to diagnose, prescribe, or treat any illness.*

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We look forward to having you!