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Do better than survive. Thrive.

Welcome To Maas Method, LLC.

Please fill out this confidential health history form as completely as you can. The more information you provide, the better we will be able to help you. If you have any questions or need any assistance in filling out these forms, do not hesitate to ask for help.

Today's Date: _____ Whom may we thank for referring you? _____

PERSONAL HISTORY

Last Name: _____ First Name: _____ MI: _____

Drivers License Number: _____ Social Security Number: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Birth Date: _____ Age: _____ Gender: _____ Female _____ Male

Marital Status (married, divorced, single, in relationship, etc.): _____ Children / Ages: _____

Occupation: _____ How many hours/week do you work? _____

Height: _____ Weight: _____ Physician: _____

Emergency Contact: _____ Relation: _____ Phone: _____

CURRENT HEALTH CONDITIONS

Primary Concern: _____

When did this first start (be specific)? _____

What makes it better? _____

What makes it worse? _____

What do you think is causing it? _____

If your concern is pain how would you rate it from 1 to 10 (10 the most intense, 0 none): _____

Is it constant or does it come and go? _____

How would you describe the pain (moving, changing, sharp, aching, tingling, etc.)? _____

Any other pains? _____

Secondary Concerns: _____

When did this first start (be specific)? _____

Have you seen an MD for your current concerns? _____ Do you have any lab/test results? _____

Do you currently see any other practitioners? (If "yes", list the type and name of practitioners.) _____

_____

Have you tried any other natural/alternative therapies for these concerns? _____

Did this treatment help you? _____

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HEALTH HISTORY

List ALL past surgeries: _____

List ALL past injuries: _____

List ALL major illnesses: _____

Current Medications: _____

Past Medications: _____

Current Supplements (and dosages): _____

Adverse Reactions to Medications or Vaccines: _____

List any allergies that you have to foods or other substances: _____

PAST MEDICAL HISTORY (Please check all that apply and date.)

□ Anemia	□ Epilepsy	□ HIV	□ Osteoporosis
□ Angina	□ Fainting	□ Hypothyroid	□ Parkinson's
□ Anorexia/Bulemia	□ Gallstones	□ Hyperthyroid	□ Pneumonia
□ Arthritis	□ Gout	□ Infection	□ Prostate Conditions
□ Arteriosclerosis	□ Hemophilia	□ Kidney Problems	□ Psoriasis
□ Autoimmue	□ Heart Disease	□ Lupus	□ Rheumatic Fever
□ Cancer	□ Pace maker	□ Lyme Disease	□ STD
□ Colitis or Chron's	□ Hepatitis	□ Metabolic Disorder	□ Stroke
□ Diabetes	□ Hernia	□ Migraines	□ TB
□ Diverticulitis	□ High Cholesterol	□ Mitral Valve Prolapse	□ Ulcers
□ Endometriosis	□ Hypoglycemia	□ MS	□ Uterine Fibroids

Clarification on any of the above: _____

_____

GENERAL

Please check all symptoms that apply to you now (check) or in the past (mark with P):

□ Night sweats	□ Weight loss	□ Fevers
□ Weight gain	□ Peculiar tastes or smells	□ Chills
□ Sudden energy drop (time?)	□ Fatigue	□ Bleed or bruise easily
□ Sweat easily	□ Change in appetite	

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GENERAL continued

How would you describe your sleep? _____

How would you describe your energy level (high / moderate / low / up and down)? _____

Do you have an unusual susceptibility to heat or cold? _____

Do you prefer warmer or cooler climates? _____

SKIN AND HAIR

□ Rashes
□ Change in hair or skin texture
□ Recent moles
□ Other hair or skin problems?
□ Itching
□ Loss of hair
□ Ulcerations
□ Eczema
□ Dandruff
□ Pimples

HEAD, EYES, EARS, NOSE AND THROAT

□ Headaches
□ Night blindness
□ Sinus problems
□ Neck pain
□ Colour blindness
□ Nose bleeds
□ Concussions
□ Cataracts
□ Jaw clicks or pain
□ Eye pain
□ Earaches
□ Tooth pain
□ Eyestrain
□ Poor hearing
□ "Silver" mercury tooth fillings
□ Blurry vision
□ Ringing in ears
□ Recurrent sore throats
□ Using glasses
□ Facial pain
□ Sore on lips or tongue

HEART AND CIRCULATION

□ High blood pressure
□ Fainting
□ Cold hands or feet
□ Dizziness
□ Low blood pressure
□ Chest pain
□ Swelling of hands
□ Blood clots
□ Irregular heart beat
□ Varicose veins
□ Swelling of feet

LUNGS AND BREATHING

□ Difficulty breathing
□ Asthma
□ Coughing blood
□ Cough
□ Pain with a deep breath
□ Pneumonia
□ Bronchitis
□ Production of phlegm (color?)
□ Other problems

DIGESTION AND ELIMINATION

□ Indigestion/Heart burn
□ Abdominal pain or cramps
□ Rectal pain
□ Bad breath
□ Gas
□ Nausea
□ Hemorrhoids
□ Constipation
□ Bloating
□ Vomiting
□ Blood in stool
□ Chronic laxative use
□ Diarrhea

How often do you have a bowel movement? _____ Quality? (formed, hard, soft, loose, etc.) _____

Is your urinary frequency more than 6x/day or less than 4x/day? _____

Do you experience night time urination? Number of times/night? _____

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WOMEN

Are you Pregnant? _____ How many months? _____

_____ Age of first menses
_____ Length of menses
_____ Length of menstrual cycle
_____ Date of start of last menses
_____ Date of last PAP exam

□ Unusual menses
□ Heavy
□ Light
□ Clots
□ Breast lumps

□ Irregular periods
□ Painful periods
□ Vaginal discharge
□ Vaginal sores

□ Do you perform a monthly self-breast exam?

□ Changes in your body or emotions prior to menstruation? _____

□ Do you practice birth control? What type and for how long? _____

Number of pregnancies: _____ Number of births: _____ Miscarriages: _____ Abortions: _____

MUSCLE, JOINTS AND BONES

□ Neck pain
□ Knee pain
□ Muscle pain
□ Other joint or bone problems?

□ Back pain
□ Foot/ankle pain
□ Hand/wrist pain

□ Muscle Cramps
□ Hip pain
□ Shoulder pain

BRAIN, NERVE AND EMOTIONS

□ Loss of balance
□ Depression
□ Concussion
□ Anxiety

□ Quick temper/irritable
□ Susceptible to stress
□ Seizures
□ Lack of coordination

□ Poor memory
□ Dizziness
□ Areas of numbness
□ Nervousness

□ Have you ever been treated for emotional problems? _____

□ Any other neurological or psychological problems? _____

STRESS

Current Stress Level 1 to 10 (10 being highest, 0 being no stress): At Work: _____ At Home: _____ Other: _____

How long have you felt like this? At Work: _____ At Home: _____ Other: _____

What would you describe as the three dominant emotions in your life at this time? (Examples include happiness, fear, sadness, anxiety, frustration, anger, grief, heartache, contentment, excitement, lethargic, moody, stressed, etc.)

_____

_____

_____

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FAMILY HISTORY

Please list the state of health and major illnesses that members of your family have had.
If relevant, include at what age they died (and what they died of).

Father: _____

Father's mother: _____

Father's father: _____

Mother: _____

Mother's mother: _____

Mother's father: _____

Brothers and Sisters: _____

Your children: _____

Other family information: _____

ACTIVITY

Write down the number of hours (to the half hour) per day you spend sedentary (lying or sitting down) in each of the following:

Lying in bed (including sleep)	_____	At the home computer	_____
Sitting in transit	_____	Sitting eating meals	_____
Sitting at work	_____	Other	_____
On the couch	_____	**Total sedentary hrs per day:**	_____

What time do you go to bed (approximately)? _____ What time do you wake up (approximately)? _____

Do you take any sleep aids? If so, which one(s): _____

Do you exercise? _____ List type and how often: _____

HABITS

How much **coffee** do you drink per week? _____ How much **alcohol** do you drink per week? _____

How much **soda** do you drink per week? _____ Do you drink **diet** or **regular** soda? _____

How much **water** do you drink **per day**? _____

Please specify type of water source (plastic bottle, home filtration system, etc.): _____

Do you smoke? _____ How much per day? _____ Recreational drugs? _____ Type and how often? _____

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FOOD AND DIET

How is your appetite (low / moderate / high)? _____ How is your thirst (low / moderate / high)? _____

Any foods/drinks that you crave? _____ Any foods/drinks that you are strongly averse to? _____

Do you follow a specific diet? (Example: vegetarian, gluten free, paleo, etc.) _____

Do you generally cook your own food? _____

Please describe your general diet.

Breakfasts: _____

Lunches: _____

Dinners: _____

Snacks: _____

Drinks: _____

Please fill in the chart indicating how often you consume the following foods:
F – Frequently (daily or more) **R** – Regularly (a few times a week) **S** – Sometimes (generally less than once a week) **N** – Never or very rarely

_____ Beans	_____ Gluten Free Products	_____ Grains	_____ Potatoes
_____ Beef	_____ Eat Out	_____ Ice Cream	_____ Raw Fish
_____ Bison	_____ Egg whites	_____ Juice	_____ Salad or Raw Vegetables
_____ Boxed cereal	_____ Eggs	_____ Lamb	_____ Soda or Energy Drinks
_____ Bread	_____ Fast Food	_____ Milk	_____ Soy Products
_____ Brown Rice	_____ Fish / Seafood	_____ Non fat dairy products	_____ Sweets / Pastries
_____ Canned Foods	_____ Fried Foods	_____ Nut Butters	_____ Turkey
_____ Cheese	_____ Frozen Prepared Foods	_____ Nuts & Seeds	_____ Vegetables
_____ Chicken	_____ Fruit	_____ Pasta	_____ White Rice
_____ Chips	_____ Gluten	_____ Pork/Ham	_____ Yogurt or Kefir

Blood Type (if known): _____

If there is anything you would like to add, please feel free to do so. If you have any questions or concerns you would like addressed, you may write them here:

_____

_____

_____

_____