*Mount Shasta Body Energy Alignment*

Dr. Neesa Ginger Mills

Confidential Health Inventory

**Personal Information**

|  |  |
| --- | --- |
| **Full name: Date:** | |
| **Address:**  Street City State Zip | |
| **Home phone:** | **Work phone:** |
| **Cell phone:** | **Email address:** |
| **Best time/place to contact you:** | |
| **Date of birth:** | **Age:** |
| **No. of children:** | **Pregnant? Yes** □ **No** □ |
| **Height:** | **Weight:** |
|  | |
| **Marital status: M S W D** | **Spouse/guardian name:** |
| **Life Focus/ Work:** | |
|  | |

**Health Concerns**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please list your health concerns according to their severity | Rate of severity  1 = mild  10 = worst imaginable | When did this begin? | Constant or sporadic? | Did the problem begin with an injury? | % of the time pain is present |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |

Do you experience physical pain? Does it radiate anywhere? If so, where?

Please list current Mental/Emotional/Spiritual health concerns?

Since the problem started is it: About the same? □ Getting better? □ Getting worse? □

What have you done to address your specified health concern? Has it helped? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which aggravates your pain or discomfort? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other practitioners you have seen for this:

|  |  |
| --- | --- |
| Chiropractor | □ |
| Dentist | □ |
| Medical Doctor | □ |
| Other (please describe) | □ |

How are your health concerns or conditions interfering with your life?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Work □ | Sleep □ | Daily routine □ | Sports/exercise □ | Mind/Emotion □ (please explain): |

**General Health History**

*The accumulation of life’s stressors – physical, mental and emotional -- can lead to health problems and influence your ability to heal.*

Have you had any surgery? (Please include all surgery)

|  |  |
| --- | --- |
| 1. Type: | When? |
| 2. Type: | When? |
| 3. Type: | When? |
| 4. Type: | When? |

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

|  |  |  |
| --- | --- | --- |
| 1. Type: | When? | Hospitalized? Yes □ No □ |
| 2. Type: | When? | Hospitalized? Yes □ No □ |
| 3. Type: | When? | Hospitalized? Yes □ No □ |

Have you ever had x-rays or an MRI taken?

|  |  |  |
| --- | --- | --- |
| Area of body: | When? | Where? |

**Your Self-Care Practices**

Exercise, Meditation, Yoga, Prayer, Outdoors, Art-making, Tantra, EFT, Therapy, Massage, Specific Spiritual path…

|  |
| --- |
|  |
|  |
|  |
|  |

**Current Medicines and Supplements**

Please list any **medications/drugs** you have taken in the past 6 months and why: (prescription and non-prescription). Include Covid-19 vaccines and boosters.

|  |
| --- |
|  |
|  |
|  |
|  |

**Nutritional supplements**, vitamins, herbs, homeopathic remedies you presently take and why:

|  |
| --- |
|  |
|  |
|  |
|  |

**Food, etc.**

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

**D** - Consume this daily | **FD** - Consume this a few times per day **| W** - Consume this weekly | **FW** - Consume this a few times per week

**FM** - Consume a few times per month (less than weekly) **| M -** Consume this monthly **| O -** Do not consume this

|  |  |  |  |
| --- | --- | --- | --- |
| Alcohol | Eggs | Gluten Foods | Artificial Sweetener |
| Tobacco | Fruit | Other Grains | Weight Control Diet |
| Coffee | Beef | Refined Sugar | Raw Vegetables |
| Cannabis | Poultry | Soda | Nuts |
| Fried Foods | Organic foods | Seafood | Dairy Products |
| Cooked or canned vegetables | | | |

The type of diet I usually follow is classified as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Health History**

Please mark the following conditions you may have had or have now (- have had/ + have now):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| □ Alcoholism | □ Allergies | □ Anemia | □ Arteriosclerosis | □ Arthritis | □ Asthma |
| □Auto Immune Disease | □ Adrenal Stress | □ Cold Sores | □ Constipation | □ Convulsions | □ Depression |
| □ Diabetes | □ Diarrhea | □ Eczema | □ Emphysema | □ Epilepsy | □ Gall Bladder Problems |
| □ Food Allergies | □ Headaches | □ Heart Attack | □ Heart Disease | □ High Blood Pressure | □ HIV (Aids) |
| □ Irregular Periods | □ Insomnia | □ Low Blood Sugar | □ Measles | □ Menstrual Cramps | □ Migraines |
| □ Back Pain | □Multiple Sclerosis | □ Neurological Disease | □ Neck Pain | □ Nervousness | □ Neuritis |
| □ Cancer | □ Pneumonia | □ Polio | □ Rheumatic Fever | □ Ringing in ears | □Sinus Problems |
| □ Stroke | □ Thyroid Problems | □Tuberculosis | □ Ulcers | □ Venereal Disease | □ Whooping Cough |

Other (please explain)

**Stressors:** Please list significant stressors and grade on a scale of 1-10; 10 being the highest possible.

1. Physical stress (falls, accidents, work postures, etc.)
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don’t drink enough water, drugs/alcohol, etc.)

1. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Eating habits: | Exercise habits: | Sleep: | General health: | Mind set: |

How do you grade your physical health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

How do you grade your emotional/mental health?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Excellent □ | Good □ | Fair □ | Poor □ | Getting better □ | Getting worse □ |

Is there anything else which may help to better understand you, which has not been discussed?

What do you hope to achieve through receiving *Body Energy Alignment*?

I understand that *Body Energy Alignment™* with Neesa Ginger Mills provides energetic, spiritual, and physical body support, and in no way promise to cure any specific disease or health condition.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_