Individual Health Information Sheet

Name ____ **Birth Date**_________________

Full Birth Name____________________________ **Location of Birth:**_______________________

Day Phone:________________________________ **Night (if different):**_____________________

Cell Phone:________________________ **Familiar with EFT Meridian Tapping? Yes**___ **No**___

Address:____

City, State, Zip :____

Email: ____________________________________ **Website?**_____________________________

In your own words, what is your main priority issue or condition for scheduling a session or series… & how long has this persisted?

How do you feel about the above?

How much & what kinds of sweaty physical activity - weekly?

Your weight: **How many ounces of water do you drink daily?**

What types water? Reverse Osmosis____ CityTap____ Spring___ Distilled___ Other____

Which meals eaten daily? Breakfast____ Lunch____ Dinner____ Snacks____ (when?)____

How many: - eliminations per day?_____ - digestive enzymes daily?_____

Exercise / Breathing exercises daily? Yes___ No___ **Describe:**

How much of the following do you consume? (example, 1D = once daily, 3M = 3 times monthly)

Alcohol	______	Dairy	______	Raw fruit	______
Bakery Goods	______	Fast food	______	Raw Veggies	______
Breads	______	Fish	______	Red Meat	______
Canned fruit	______	Frozen foods	______	**Smoking**	______
Canned Veg.	______	Fruit juices	______	Soda pop	______
Canola	______	Pizza	______	**Soy**	______
Coffee	______	Poultry	______	**Sugar**	______
Corn	______	Processed Meat	____	**Wheat**	______

What types of food do you crave? Salty___ Chocolate___ Sweets___ Breads___ Other______________

What are your favorite foods?

How much daily energy do you have? (1 = lowest energy level; 10 = highest energy level) _____________

What surgeries have you had and when? List NONE if applicable.

How many hours of TV do you watch? Daily:____ Weekly:____ News:____ Movies:_____

How many hours of spiritual enrichment each week? (Bible, prayer, church, etc.) _______

How many hours a week do you spend with family/friends? _____

How many hours of sleep do you get each night?_____ How many hours do you need?______

What prescription medications or other drugs do you take? List NONE if applicable.

What homeopathics, natural remedies, herbs, supplements do you take? List NONE if applicable.

What are your life goals for the next 1-2 years?

How did you hear about me & my practice?

I understand that I am here for whole person success & wellness coaching and support to identify hidden issues or imbalances that may be making me sick or uncomfortable, and to learn about better wholistic health practices that relate to my symptoms. I understand that I will be offered information as well as natural health processes, energy remedies, or holistic techniques. These may be used to assess and re-balance detrimental life patterns or decisions, mental thought pathways, meridian energy channels, and more, for improved over-all health and well-being.

The services performed here are at all times limited to consultation on the symptoms involving emotional, psychological, energetic, spiritual, and nutritional matters intended for the maintenance of the best possible state of natural health and balance; they do not involve the diagnosing, treatment, or prescribing of remedies for disease.

I fully understand that Dr. Anne Merkel is not a medical doctor, and I am not here for medical diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit as an agent for federal, state, or local agencies or on a mission of entrapment or investigation. **-- I give Dr. Merkel my full permission to use the holistic and natural tools that she deems will be of most benefit to my body-mind-spirit over-all present and future health and well-being.**

Signature____

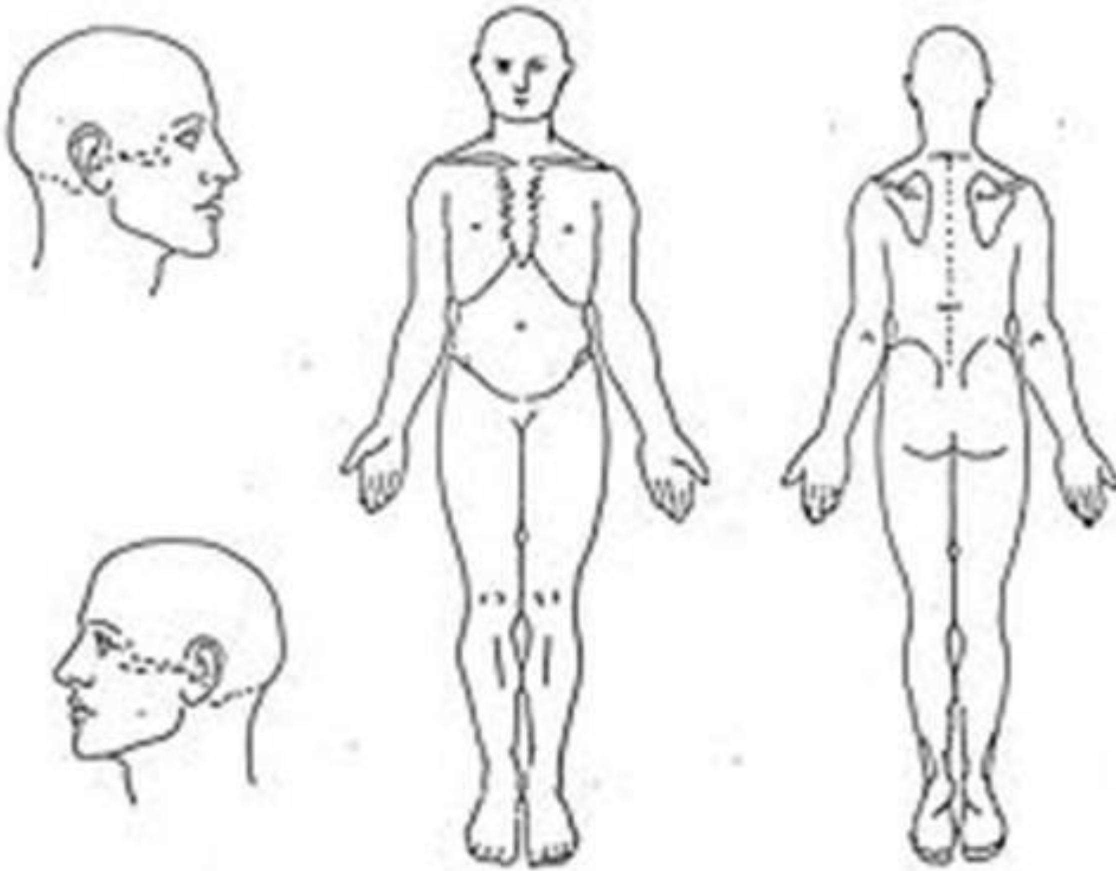
Date______________________________________ **Payment Method**_________________________

Single Session(s)_____ **6-Session Series**_____ **6-Month Maintenance**_____

Symptoms and Areas of Concern (check or highlight all that apply now or in last 3 mos)

— Acne
— ADD/ADHD
— Adrenal Glands
— Allergies
— Alzheimer's Disease
— Anemia
— Anger
— Anxiety
— Appetite
— Arteriosclerosis
— Arthritis
— Asthma
— Back Pain
— Bad Breath
— Bed Wetting
— Bell's Palsy
— Bites
— Bladder
— Blood Pressure - High
— Blood Pressure - Low
— Boils
— Bones Fever
— Breathing
— Bronchitis
— Bruises
— Burns
— Cancer
— Candida
— Canker Sores
— Carpal Tunnel
— Cataracts
— Chest Congestion
— Chest Pain
— Cholesterol
— Circulation
— Cold - Common
— Cold - Temperature
— Colic
— Colon
— Constipation
— Cough
— Cravings
— Dandruff
— Depression
— Diabetes
— Diarrhea
— Digestion
— Dizzy Spells
— Ear Infection
— Ear Ringing
— Edema
— Emphysema
— Epilepsy
— Eyesight
— Fatigue
— Flu
— Gallstones
— Gangrene
— Gas
— Gout
— Gums
— Hair Issues
— Headache
— Heart Issues
— Heartburn
— Hemorrhoids
— Herpes PMS
— Hiatal Hernia
— Hives
— Hormones
— Hyperactive
— Hypertension
— Hyperthyroid
— Hypoglycemia
— Impotence
— Incontinence
— Indigestion
— Insomnia
— Joint Pain
— Kidney Issues
— Kidney Stones
— Laryngitis
— Leprosy
— Leukemia
— Liver
— Lung Issues
— Lupus
— Lymph Glands
— Menopause
— Menstrual Cramps
— Migraines
— Mononucleosis
— Mucous
— Nails
— Nausea
— Nervousness
— Nose Bleeds
— OTHER:
— Parasites
— Parkinson's Disease
— Perspiration
— Pneumonia
— Polyps
— Pregnancy
— Prostate
— Psoriasis
— Rash
— Reproductive
— Respiratory
— Rheumatism
— Ring worm
— Seizures
— Shingles
— Sinus
— Skin Issues
— Snoring
— Sore Throat
— Stomach
— Stress
— Stroke
— Sty
— Teething
— Tennis Elbow
— Tonsillitis
— Tumors
— Ulcers
— Urinary Infections
— Varicose Veins
— Vertigo
— Weight - Overweight
— Weight - Underweight
— Yeast Infections

Pain & Symptom Body Areas:



Please mark your areas of pain or symptoms on the diagram above… and scan to send, or bring a printed copy to your first session.   Thank you!

Also, list below any comments you have about your painful or symptomatic areas.

Bach Flower Self-Help Energy Medicine Questionnaire

Check (or highlight) all that apply. If you have to think about it, skip it. Don't limit your choices.

Agrimony
___I hide my feelings behind a facade of cheerfulness
___I dislike arguments and often give in to avoid conflict
___I turn to food, work, alcohol, drugs, etc. when down
Aspen
___I feel anxious without knowing why
___I have a secret fear that something bad will happen
___I wake up feeling anxious
Beech
___I get annoyed by the habits of others
___I focus on others' mistakes
___I am critical and intolerant
Centaury
___I often neglect my own needs to please
___I find it difficult to say "no"
___I tend to be easily influenced
Cerato
___I constantly second-guess myself
___I seek advice, mistrusting my own intuition
___I often change my mind out of confusion
Cherry Plum
___I'm afraid I might lose control of myself
___I have sudden fits of rage
___I feel like I'm going crazy
Chestnut Bud
___I make the same mistakes over and over
___I don't learn from my experience
___I keep repeating the same patterns
Chicory
___I need to be needed and want my loved ones close
___I feel unloved and unappreciated by my family
___I easily feel slighted and hurt
Clematis
___I often feel spacey and absent minded
___I find myself unable to concentrate for long
___I get drowsy and sleep more than necessary
Crab Apple
___I am overly concerned with cleanliness
___I feel unclean or physically unattractive
___I tend to obsess over little things
Elm
___I feel overwhelmed by my responsibilities
___I don't cope well under pressure
___I have temporarily lost my self-confidence
Gentian
___I become discouraged with small setbacks
___I am easily disheartened when faced with difficulties
___I am often skeptical and pessimistic
Gorse
___I feel hopeless, and can't see a way out
___I lack faith that things could get better in my life
___I feel sullen and depressed
Heather
___I am obsessed with my own troubles
___I dislike being alone and I like to talk
___I usually bring conversations back to myself

Holly
___I am suspicious of others
___I feel discontented and unhappy
___I am full of jealousy, mistrust, or hate
Honeysuckle
___I'm often homesick for the "way it was"
___I think more about the past than the present
___I often think about what might have been
Hornbeam
___I often feel too tired to face the day ahead
___I feel mentally exhausted
___I tend to put things off
Impatiens
___I find it hard to wait for things
___I am impatient and irritable
___I prefer to work alone
Larch
___I lack self-confidence
___I feel inferior and often become discouraged
___I never expect anything but failure
Mimulus
___I am afraid of things such as spiders, illness, etc.
___I am shy, overly sensitive, and modest
___I get nervous and embarrassed
Mustard
___I get depressed without any reason
___I feel my moods swinging back and forth
___I get gloomy feelings that come and go
Oak
___I tend to overwork and keep on in spite of exhaustion
___I have a strong sense of duty and never give up
___I neglect my own needs in order to complete a task
Olive
___I feel completely exhausted, physically and/or mentally
___I am totally drained of all energy with no reserves left
___I've just been through a long period of illness or stress
Pine
___I feel unworthy and inferior
___I often feel guilty
___I blame myself for everything that goes wrong
Red Chestnut
___I'm overly concerned and worried about my loved ones
___I'm distressed and disturbed by other people's problems
___I worry that harm may come to those I love
Rock Rose
___I sometimes feel terror and panic
___I become helpless and frozen when afraid
___I suffer from nightmares
Rock Water
___I set high standards for myself
___I am strict with my health, work &/or spiritual discipline
___I am very self-disciplined, always striving for perfection

Scleranthus
___I find it difficult to make decisions
___I often change my opinions
___I have intense mood swings
Star of Bethlehem
___I feel devastated due to a recent shock
___I am withdrawn due to traumatic events in my life
___I have never recovered from loss or fright

Sweet Chestnut
___I feel extreme mental or emotional heartache
___I have reached the limits of my endurance
___I am in complete despair, all hope gone
Vervain
___I get high-strung and very intense
___I try to convince others of my way of thinking
___I am sensitive to injustice, almost fanatical
Vine
___I tend to take charge of projects, situations, etc.
___I consider myself a natural leader
___I am strong-willed, ambitious and often bossy
Walnut
___I'm experiencing change in life–a move, new job, etc.
___I get drained by people or situations
___I want to be free to follow my own ambitions
Water Violet
___I give the impression that I'm aloof
___I prefer to be alone when overwhelmed
___I often don't connect with people
White Chestnut
___I am constantly thinking unwanted thoughts
___I repeatedly relive unhappy events or arguments
___I'm unable to sleep at times because I can't stop thinking
Wild Oat
___I can't find my path in life
___I am drifting in life and lack direction
___I am ambitious but don't know what to do
Wild Rose
___I am apathetic and resigned to whatever happens
___I have the attitude, "It doesn't matter anyhow"
___I feel no joy in life
Willow
___I feel resentful and bitter
___I have difficulty forgiving and forgetting
___I think life is unfair and have a "Poor me attitude"

Determining Your Custom Remedy

After completing the questionnaire, circle the remedy names where two or more checks appear to determine which remedies are needed. Try to limit the number of remedies to six or fewer by choosing only the ones that are needed and checked most. List your top 6 below:

1.
2.
3.
4.
5.
6.

Pre-Session Energy Medicine Information & Timeline

1. **List all of the specific Emotional Issues or Physical Symptoms you are experiencing right now.**

2. **Now rate each issue on the above list by emotional charge/ physical discomfort using a 0-10 scale where 0=no charge/pain – 10=severe.**

3. **Generally describe your present diet:** (non-gluten, paleo, OG/ non-GMO, vegetarian, vegan, traditional southern, Mediterranean, elimination, etc.)

4. **Briefly describe your own Spiritual or Religious belief system**: (I regularly attend a Catholic/Protestant/Jewish/other service, I meditate, I feel connected with Spirit/God/Angels/The Universe, I have my own Spiritual feelings, I pray to ___, I am a member of a Spiritual community, etc.) [This is helpful to me as I customize your program for you.]

5. **List here anything you know about the following from the time of your conception through age 10:** (Parent's attitudes about pregnancy with you, mother's pregnancy experience, traumas during pregnancy, early living environment & setting, socio-economic issues, temperaments of parents, over-all tone of your early life, repeated actions, comments, complaints, declarations by others around you, etc.)

6. **It will be helpful in our work if you provide a <u>time line</u> of all accidents, physical issues/illnesses, negative emotional life-impacting episodes, surgeries, traumas, etc. that have impacted your mind, body, spirit. (**You don't need to go into great detail… just list your age and then: "car accident", "divorce", "disappointment", "miscarriage", "job lay-off or lost contract", etc.)

7. **Threats or Challenges that you are facing now in your life** - (What's holding you back?):

8. **Opportunities, insights, and breakthroughs available to you now –** (What/Who is supporting you?):

9. **What is your main intention for the <u>results</u> of our first session together?**

Send the answers on this entire form to me 24-48 hours prior to your session to save time in your session. Send to: *info@arielagroup.com* .Or you may copy and mail to: Dr. Anne Merkel / P.O. Box 305 / Mineral Bluff, GA 30559.