Spinal Flow Health Questionnaire

Personal Details

Name	
Date of Birth	
Telephone Number	
Email Address	

About your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, which have resulted in poor health. During your sessions we will begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness (Birth - Age 5)

Let's begin at birth when you may have first damaged your nervous system, lost your wellness, and began your journey to ill health.

Please check Yes / No and add comments where applicable:

Birth Process		Client Comment
Was the delivery long and/or difficult?	Yes / No	
Were Forceps or suction used?	Yes / No	
Was the birth Cesarean?	Yes / No	
Breech / Cephalic?	Yes / No	

Do you know of any stressful situation that may have been present for your mother or father or both?

Growth and Development		Client Comment
Did you roll out of bed or have any falls as a child?	Yes / No	
Any Childhood illnesses?	Yes / No	
Did you have other traumas?	Yes / No	
If so what?		
If so when?		
Did you have colic, reflux or difficulty feeding?	Yes / No	
Were there any stressful events that occurred in this time?	Yes / No	

Loss of Whole Body Health (Age 5 - Present)

As you increase the layer of damage you probably begin to experience symptoms and random bouts of sickness.

Do you smoke?	Never	Did previously	Weekly	Daily
Do you drink Alcohol?	Never	Did previously	Weekly	Daily
Do you take recreational Drugs?	Never	Did previously	Weekly	Daily
Have you recently taken recreational drugs? If so please list them along with number of days/weeks since taking.				
Do you take over the counter Drugs? (Prescriptive or Non-prescriptive)	Never	Have recently	Currently taking	
Have you recently taken prescription drugs? If so please list them along with number of days/weeks since taking. *Please include the drug function for eg, blood pressure, anti-arthritis etc*				
Do you eat healthy?	Yes	Try to	No	
Have you been in any Accidents?	Yes / No			
Have you had surgery and organs removed or replaced?	Yes / No			

Do you have trouble sleeping? *Sleep debt, wake up tired, etc.*	Yes / No		
Sleeping Posture:	Side	Stomach	Back
Did you / Do you have occupational stress?	Yes / No		
Physical and/or Mental stress?	Yes / No		
Hobby / Sports injuries?	Yes / No		
Other Traumas or problems?	Yes / No		
Were there any stressful events that have caused an impact on your health and wellbeing? If yes please state.			

Present State of Health (Symptoms)

What is your body telling you right now? What symptoms are you experiencing? Please explain and describe what is happening in your body.	
When did this start?	
What do you think the cause is?	
What activities aggravate your condition?	
What lessens your condition?	
Is this condition interfering with: Work Sleep Routine Other:	
What is this stopping you from doing?	
If this was to go away tomorrow, what would be different about your life?	
Are you living the life you would like to be?	Yes / No
On a scale of 0-10, how happy are you? *10 = extremely 1 = not at all.*	1 2 3 4 5 6 7 8 9 10
On a scale of 0-10, how much stress is in your life? *10 = A lot, 1 = none.*	1 2 3 4 5 6 7 8 9 10
Are you ready to make changes to your life in order to heal, even if these changes could be inconvenient to your lifestyle? Yes / No	

Any Other Symptoms you are experiencing

Please mark with a tick or asterisk.

Neck Pain	Numbness in Fingers	Nervousness
Stiff Neck	Shoulder Pain	Tension & Irritability
Headaches	Cold Feet/Hands	Fatigue
Dizziness	Loss of Smell/Taste	Chronic Fatigue
Fainting	Cold/Flu	Depression
Ringing in Ears	Allergies	Pins & Needles (legs)
Balance Loss	Pain in Mid Spine	Shortness of Breath
Numbness in toes	Cold Sweat	Weight Problems
Chest Pain	Hearing Problems	Stomach/Digestive Problems
Fever	Sensitive to Light (eyes)	Constipation/Diarrhea
Loss of Memory	Menstrual Pain	Pins & Needles (arms)
Migraines	Stress	Difficulty Breathing
Thyroid Issues	Not Sleeping	Lower back pain
Sciatica	Fibromyalgia	Knee Pain

What are you looking to get out of this session (set of sessions)?

Have you had any trauma or abuse in your life?

Please let us know in a few paragraphs, how we can assist you and help you the most.

Agreement

By signing this form, I agree and consent to the healing work while I am on this course of treatment.

I understand that with any healing process and work on my body, my symptoms may worsen before they get better.

I understand this program is designed to assist the body with healing by helping to remove stressors from the body. I understand that healing takes time and there is no quick immediate fix to my problem, and health is a process.

I have freely decided to undergo the recommended treatment and hereby give my full consent to the treatment.

Client Name: _____

Client Signature:_____

Date: _____

Please wear loose comfortable clothing without belts or heavy seams (as in jeans) to get the most from your session.

The Health Hub

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