Contact:
highergroundheal@gmail.com
highergroundhealing.ca

Date mm: ___/dd: ___/yyyy: _____

CLIENT PERSONAL INFORMATION:

Name: _____	Ht.: ____in.	Wt.: ____lbs.	Age: _____
Male or Female: --select-- ☐	Date of Birth: _____/_____/_____	Eye Color: _____	
Address: _____	City: _____		
State (if applicable): _____	Zip Code: _____	E-mail: _____	
Country: _____	Province: _____	Int'l Dialing Code: _____	
Home Phone: (_____)_____	Work Phone: (_____)_____	Fax: (_____)_____	
Alt./Cell Phone: (_____)_____	Do you have Skype? Y.:☐ N.:☐	Screen name: _____	
Family Physician: _____	Phone: (_____)_____		
Other Provider: _____	Phone: (_____)_____		

CLIENT VITALS INFORMATION:

If unable to answer a section, leave blank

What is Your Blood Pressure?	Left Side: _____/_____	Right Side: _____/_____	
Pulse: _____BMP	Respirations: _____	Basal Temperature: _____	
Results of your pH test(s)?	Saliva pH: _____	Urine pH: _____	
How many bowel movements do you have?	Per Day: _____	Per Week: _____	

GLANDULARS:

Glandulars may be recommended to support regeneration of very weak glands and/or organs.
Please check the relevant box below to assert whether or not you want glandulars considered:

YES: ☐ **NO:** ☐

HEALTH QUESTIONNAIRE
A SELF-ASSESSMENT

Please check **Yes** or **No** where applicable. If filling out a printed copy, please circle the appropriate option(s) in **bold** and add comments as necessary.

Yes	*No*	**THYROID/PARATHYROID (Glandular System)**
		Do you get cold hands and/or feet?
		Is it easy to put on weight and hard to lose it?
		Is your bladder strong or weak? --select--
		Do you have low energy levels?
		Do you suffer from symptoms of depression?
		Do you get irritable easily?
		Do you bruise easily?
		Do you get cramping in your muscles?
		Do you sweat **normally** ☐ , **profusely** ☐ or **hardly at all** ☐ ?
		Do you have an irregular heartbeat?
		Do you have Mitral Valve Prolapse (*Heart Murmur*)?
		Do you get headaches or migraines?
		Have you ever had an aneurysm?
		Do your lab tests come back showing low calcium levels?
		Did you score low on your bone density tests?
		Do you have osteoporosis?
		Do you have scoliosis?
		Do you have spine deterioration or herniated discs?
		Are your fingernails ridged, brittle or weak?
		Do you have, or have you ever had, hemorrhoids or hernias?
		Do you have any prolapsed organs?
		Do you have varicose or spider veins?
		Do your legs get tired or cramp after you walk?
		Have you been diagnosed with Hashimoto's or Reidel's thyroiditis? Has a family member?

Yes	*No*	**PANCREAS**
		Do you see any undigested foods in your stools?
		Do you feel your foods just sitting in your stomach?
		Do you have acid reflux?
		Do you get gas after you eat?
		Are you thin and have a hard time putting on weight?
		Do your foods pass right through you (*diarrhea*)?
		Do you have moles on your body?

Yes	*No*	**ADRENAL GLANDS (medulla) (Glandular System)**
		Are you overweight?
		Do you have M.S., Parkinson's or Palsy? If yes, please specify: --select--
		Do you feel excessive shyness or inferior to others?
		Do you have *anxiety attacks* or feel *overly anxious?*
		Do you have a hard time sleeping or insomnia? (pineal gland)
		Do you have tremors, nervous legs, etc.?
		Do you have tinnitus (ringing in the ears)?
		Do you have hypoglycemia (low blood sugar)?
		Do you have diabetes (high blood sugar)? If yes: Type I ☐ OR Type II ☐
		Do you have heart arrhythmias?
		Do you have *shortness of breath*?
		Do you have Chronic Fatigue Syndrome?
		Have you ever been diagnosed with Addison's Disease or Congenital Adrenal Hyperplasia?
Yes	No	**ADRENAL GLANDS (cortex) (Glandular System)**
		Do you have elevated blood cholesterol levels?
		Do you have low steroids or cortisol levels?
		Do you have arthritis, bursitis, or any inflammatory issues?
		Do you have any other "-itis" (inflammatory) conditions? If yes, state them below.
Inflammatory conditions:		

Yes	*No*	**FEMALES ONLY**
		Are your menstruation's irregular? (pituitary gland)
		Do you get excessive bleeding during menstruation?
		Do you **have** or have you ever **had** a yeast infection? How often? _____
		Do you **have** or have you ever **had** ovarian cysts?
		Do you **have** or have you ever **had** uterine fibroids?
		Do you **have** or have you ever **had** endometriosis or A-typical cells?
		Do you have fibromyalgia or scleroderma?
		Do you get sore breasts, especially during menstruation?
		Do you have a **low** or **excessive** sex drive?
		Have you had a hysterectomy? Date mm: ___yyyy: _____ ***Partial:*** ☐ *OR* ***Complete:*** ☐
		Did they take any other organs out at the same time?
		If so, which organ(s)? _____
		Have you had a dilation and curettage procedure? Date mm: ___ yyyy: _____
		Have you had a miscarriage?
		Have you had difficulty in conceiving children?
		Have you been on Birth Control Pills? If, yes, how long? _____
		Are you currently pregnant?

Yes	*No*	**MALES ONLY**
		Do you have prostatitis (*frequent urination esp. at night*)?
		If yes, how often do you urinate? _____
		Do you have prostate cancer? PSA counts: _____ Date of test mm: ____ yyyy: _____
		Do you have testicular hypertrophy (*enlargement*)?
		Do you have a **low** or **excessive** sex drive? --select--
		Do you have erection problems?
		Do you have premature ejaculation?

Yes	*No*	**GASTROINTESTINAL TRACT**
		Do you have **gastritis**, **enteritis, colitis** or **diverticulitis?**
		If yes, please specify which: --select--
		Is your tongue coated (*white, yellow, green or brown*), especially in the morning?
		Do you have gastroparesis?
		Do you have a Hiatus Hernia?
		Do you have gas problems?
		Do you get or have Constipation?
		Do you get or have Diarrhea?
		Do you or have you ever had, stomach or intestinal ulcers?
		Do you have Crohn's Disease?
		Do you or have you ever had any type of gastro-intestinal cancers?
		Stomach, **colon**, **rectal**, etc? Please specify: _____
		Any other gastrointestinal tract issues? If yes, please specify below.

Yes	*No*	**LIVER/GALLBLADDER/BLOOD**
		Do you have a problem digesting fats?
		Do you have, or have you ever had, hepatitis? If so: **A** ☐, **B** ☐, or **C** ☐?
		Do fats or dairy foods cause bloating and/or pain in the stomach area?
		Are your stools white or very light brown in color?
		Do you get pain in the middle of your back (*especially after eating*)?
		Do you get pain behind the right, lower rib area?
		Do you have "liver" or brown spots on your skin? (*not freckles*)
		Do you have any skin pigmentation changes?
		Do you have skin problems? If so, what type? _____
		Are you or have you ever been anemic?

Yes	*No*	**HEART & CIRCULATION**
		Do you get **chest pains** or **angina**?
		Have you ever had a heart attack (*Myocardial Infarction*)?
		Do you **have**, or have you ever **had** High Blood Pressure? (kidneys)
		Do you ever feel pressure on your chest?
		Do you have heart arrhythmias?
		Do you have a heart murmur or Mitral Valve Prolapse?
		Have you ever had open-heart surgery?
		Do you get "prickly" pains anywhere, especially in the heart area?
		Where? _____
		Do you have a pacemaker or stints? If yes, please specify: _____

Yes	*No*	**LUNGS**
		Do you **get** or have (or have had) **had** bronchitis?
		Do you **get** or have (or have had) **had** asthma?
		Do you **have** or have you ever **had** emphysema?
		Do you **have** or have you ever **had** C.O.P.D?
		Are you on inhalers or nebulizers? How often? _____
		What type? _____
		Do you know what your oxygen saturation is? If yes, please state: _____
		Do you get pain when you breathe?
		Do you get pain when you take a deep breath?
		Do you **have** or have you ever **had** lung cancer?
		Do you have a collapsed lung?
		Have you ever had pneumonia?
		Have you ever worked around toxic chemicals, in coal-mines or around asbestos?
		Do you cough a lot?
		Do you get any mucus when you cough? What color is the mucus? _____

Yes	*No*	**SKIN**
		Do you get or have skin rashes?
		Do you get skin blemishes?
		Do you have **Eczema** or **Dermatitis**?
		Do you have Psoriasis?
		Do you itch anywhere? Where? _____
		Is your skin dry?
		Is your skin excessively oily?
		Do you get or have dandruff?
		Do you have skin problems? If so, what type? _____

Yes	*No*	**LYMPHATIC SYSTEM**
		Do you have hair loss or are you bald or going bald?
		Do you have swollen lymph nodes?
		Have you ever had any lymph nodes removed? How many? ___
		Where? _____
		Have you had your tonsils out? If yes, at what age? _____
		Do you **have**, or have you ever **had**, a goiter?
		Do you have a hard time remembering things?
		Is your immune system weak or sluggish?
		Do you ever get colds or flu-like symptoms?
		Do you have fibromyalgia or scleroderma?
		Do you **have** a sore throat or **get** sore throats often?
		Do you have sinus problems?
		Have you had **appendicitis** or an **appendectomy**? When? _____
		Do you **have** or have you **had** tumors? What type? **Fatty**☐, **Benign**☐, or **Cancerous**☐.
		Where? _____
		Do you get **boils**, **pimples**, and the like?
		Do you **have**, or have you ever **had**, cellulitis?
		Have you ever had abscesses?
		Have you ever had gout?
		Have you ever had toxemia?
		Do you have a low platelet count (blood)?
		Do you get blurred vision?
		Do you have mucus in your eyes when you wake up in the morning?
		Do you snore?
		Do you have sleep apnea?

Yes	*No*	**KIDNEYS & BLADDER**
		Have you ever had a urinary tract infection (*UTI's*)?
		Have you ever experienced "burning" upon urination?
		Do you have problems holding your bladder?
		Have you ever had kidney stones?
		Do you have bags under your eyes (*esp. in the morning*)?
		Is your urine flow restricted?
		Do you get cramping or pain on either side of your mid-to-lower back?
		Do you **have** or have you ever **had** sciatica?
		Do you **have** or have you ever **had** nephritis?
		Do you **have** or have you ever **had** cystitis?

Chemical Medications - *Please list any chemical medications that you are presently taking:*

MEDICATION NAME	REASON FOR TAKING
1.)	
2.)	
3.)	
4.)	
5.)	
6.)	
7.)	
8.)	

Natural Supplements - *Please list any natural supplements you are currently taking:*

SUPPLEMENT(S)	
1.)	*6.)*
2.)	*7.)*
3.)	*8.)*
4.)	*9.)*
5.)	*10.)*

Surgeries - Please list any past surgeries you have had (*e.g. tonsils removed, hysterectomies, open heart surgery, etc.):*

SURGERY	DATE OF SURGERY	
1.)	*mm: ___*	*yyyy: ___*
2.)	*mm: ___*	*yyyy: ___*
3.)	*mm: ___*	*yyyy: ___*
4.)	*mm: ___*	*yyyy: ___*
5.)	*mm: ___*	*yyyy: ___*
6.)	*mm: ___*	*yyyy: ___*

Yes	*No*	ENVIRONMENTAL TOXINS
		Have you been vaccinated?
		Have you had shots for travelling to foreign countries?
		Have you had Flu shots?
		Do you find it difficult to take deep breaths?
		Have you been exposed to nuclear wastes or by-products, heavy metals or chemicals?
		Have you had **radiation** or **chemotherapy**? If so, how many treatments? --select--

Sleep – *Please describe how much sleep you get/need on average per day:*

SLEEP PATTERN

Allergies – *Please list anything that you are allergic to:*

ALLERGIES

AMALGAM FILLINGS			
Do you have, or have you had, any dental amalgam fillings?		***Yes*: ☐**	***No*: ☐**
If yes, how many?	***In the past*: _____**	***Currently*: _____**	

ALCOHOL		CAFFEINE		TOBACCO	
Do you consume alcohol?		Do you consume caffeine?		Do you smoke?	
***Yes*: ☐**	***No*: ☐**	***Yes*: ☐**	***No*: ☐**	***Yes*: ☐**	***No*: ☐**

GENETIC HEALTH HISTORY
Mother:
Father:
(Maternal) Grandfather:
(Maternal) Grandmother:
(Fraternal) Grandfather:
(Fraternal) Grandmother:
Sister:
Sister:
Brother:
Brother:

WHAT ARE YOUR PRIMARY HEALTH COMPLAINTS OR CONCERNS? Please list and elaborate on any conditions or symptoms that this questionnaire has not covered or asked you.

-Thank you-