perfect resonance™
natural health counselling

Anna Varriano, B.Sc., R.N.C.P., N.H.C.

www.perfectresonance.com
info@perfectresonance.com

Phone Number: 613-299-4022

CONFIDENTIAL CASE HISTORY

Name _____ Birth Date _____ Age ____ M/F _____

Address_____ City _____ Zip/Postal Code _____

Occupation _____ Height _____ Weight _____ Marital Status _____

# of Children _____ Family Doctor _____Specialists _____

Phone (Home) _____ (Work) _____ Cell _____

Email _____

Please indicate the ailments listed by checking the boxes below which may pertain to you:

☐	Heart trouble	☐	Lower back pain	☐	Bloating
☐	Varicose veins	☐	Muscle pain	☐	Pain after eating
☐	Arteriosclerosis	☐	Spinal issues	☐	Ulcers
☐	Stroke	☐	Fibromyalgia	☐	Burping/heartburn
☐	Poor circulation	☐	Sciatica	☐	Nausea
☐	High blood pressure	☐	Carpal tunnel	☐	Hypoglycemia/Low blood sugar
☐	Low blood pressure	☐	Tendonitis	☐	Diabetes/High blood sugar
☐	Chest/Upper back pain	☐	Leg pains/cramps/spasms	☐	Alternating blood sugar
☐	Excessive sweating	☐	Skin rashes	☐	Low Energy
☐	Hemophilia	☐	Dry skin	☐	Fatigue
☐	Migraines	☐	Dandruff	☐	Chronic fatigue
☐	Dizziness	☐	Eczema	☐	Insomnia
☐	Headaches	☐	Psoriasis	☐	Jerky motions
☐	Body weight issues	☐	Allergies	☐	Epilepsy
☐	Thyroid function (high/low)	☐	Kidney infection	☐	PMS
☐	Shortness of breath	☐	Bladder infection	☐	Hormonal Imbalance
☐	Lung disorders	☐	Pain with urination	☐	Hot flashes
☐	Increased mucus	☐	Interrupted urine flow	☐	Mood swings
☐	Repetitive clearing of throat	☐	Incontinence	☐	Anxiety
☐	Coughing	☐	Edema, if yes, where? _____	☐	Depression
☐	Persistent dry cough	☐	Digestive disorders	☐	Panic attacks
☐	Coughing up mucus	☐	Constipation	☐	Nervousness
☐	Asthma	☐	Diarrhea	☐	Feelings of persistent sadness
☐	Sinus problems	☐	Alternating const./diarrhea	☐	Melancholy
☐	Arthritis	☐	Gas/Flatulence	☐	Irritable
☐	Joint pain				

WATER: How many 8oz glasses/bottles/cups per day? _____

What type of water (e.g., tap, well, bottled, etc.) _____

If you drink any of the following, indicate how many cups/glasses per day:

Coffee ____ Tea ____ Herbal Tea ____ Milk ____ Fruit juice ____ Veg. Juice ____ Diet Soda ____

Soda ____ Filtered water ____ Bottled water ____ Tap water ____

When do you drink your water? _____

EXCERSISE: How many days/weeks? _____ For how long? (mins/hrs) _____ Type _____

SLEEP: How many hours per night? (average) _____ Do you wake rested? Yes ☐ No ☐

Is sleep interrupted? Yes ☐ No ☐ How often? _____ At what time(s) _____

Due to urination? Yes ☐ No ☐

Do you **SMOKE**? Yes ☐ No ☐ If yes, how many cigarettes a day? ____

Have you **ever** smoked? Yes ☐ No ☐ Age started ____ For how long? _____

Does anyone else in your family/household/work smoke? Yes ☐ No ☐

ALCOHOL: How often (per/day or per/week) do you have: Beer _____ Wine (red/white) _____

Mixed drinks _____ Liqueurs/ice wine _____ If any, how much? _____

Have you ever been treated for alcoholism? Yes ☐ No ☐ If yes, how long ago? _____

DRUGS: Do you use any recreational drugs? Yes ☐ No ☐ Type _____ How often? _____

Have you **ever** used any recreational drugs? Yes ☐ No ☐ Type _____ How often? _____

Have you ever been treated for drug dependency? Yes ☐ No ☐ If yes, how long ago? _____

WORK: How many hours per day? _____ How many days per week? _____

Do you enjoy your work? Yes ☐ No ☐ What is your occupation? _____

LEISURE: How many hrs per day do you: Watch TV _____ Read _____
Listen to music _____ (state type listened to _____)
Sit in front of a computer _____
Practice spiritual or relaxaton methods _____ (state type practiced _____)

Do you take vacations? Yes ☐ No ☐ If yes, how often? _____

When was your last vacation? _____

STRESS: Level you are experiencing now: ☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

Is the main stressor: ☐ Financial ☐ Job-related ☐ Interpersonal ☐ Marriage ☐ Health
☐ Unfulfilled expectations ☐ Family members ☐ Spiritual

CHIEF COMPLAINT/CONCERN: What are your main health complaints/reason for visit?

_____
_____
_____

Other therapies: Please list other therapies you are having. (e.g. chiropractic, physio, acupuncture, etc.)

_____
_____

What are you taking now and why?

Over-the-counter drugs _____

Vitamins/Minerals _____

Herbal Remedies _____

Prescription drugs _____

Other _____

Have you ever been hospitalized? Yes ☐ No ☐ If so, why? _____

FAMILY HISTORY: List hereditary diseases; age; relative health. If deceased, reason for death.

Grandparents: _____

Father: _____

Mother: _____

Brother/Sister: _____

Children: _____

Female: Are you pregnant? Yes ☐ No ☐ Number of successful pregnancies ____

Number of miscarriages _____ Menopausal? Yes ☐ No ☐ Peri-menopausal? Yes ☐ No ☐
Hysterectomy? Yes ☐ No ☐ If yes, full, or partial? _____

DIETARY HABITS: Please list what you ate and drank in your last three meals and snacks:

Breakfast: _____ Supper: _____

_____ _____

_____ _____

Lunch: _____ Snacks: _____

_____ _____

_____ _____