

Zihna's Light/Vibrational Healing

Health History Form

Date: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Family health history:

Cancer, diabetes, TB, alcoholism, allergies, etc.

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Paternal Grandparents: _____

Maternal Grandparents: _____

Patient History:

Major Illnesses: _____

Surgeries: _____

Emotional Traumas: _____

Present complaints: _____

History form page 2

Physical characteristics:

Hair color: _____ Eye color: _____ Skin color: _____

Complexion: _____ Build: _____

Posture: _____

Height: _____ Weight: _____

Birthmarks, moles: _____

Describe your personality- positive and negative traits: _____

What do you have fear or anxiety about? _____

What kinds of things do you enjoy doing? _____

What kinds of things do you dislike doing? _____

Favorite temperature/ climate/ season: _____

Best and worst time of day for you? _____

Usual sleep position and amount of covers you like: _____

Are your physical problems more on one side? If so, which side?

What kind of diet do you have? (*Traditional, vegan, etc*) _____

History form page 3

Foods you dislike?/ Crave: _____

Do you have any allergic reactions to food? If so, what?

What kind of appetite do you have?

Do you like..?

Sweets: ___ Salty: ___ Spicy: ___ Sour: ___ Fats: ___

Chocolate: _____

Cold drinks: _____ Hot drinks: _____

Chew ice or popsicles: _____

Do you enjoy...?

Music: _____ Dancing: _____ Sports: _____ Outdoors: _____

Animals: _____

Do you have good rhythm? _____ Are you intense/ focused? _____

How do you feel about confrontations? Like them: ___ Dislike: them ___

Do you prefer? Crowds: ___ Being alone: ___

A few people: _____

Do you fear...?

Heights: ___ Bridges: ___ Water/dams: ___ Dark: _____

Being Alone _____

Public speaking: _____ (Now or in the past) Insects: _____

Animals: _____

Are you a morning person? _____ A night Owl? _____

Do you like to be comforted? _____ Find it uncomfortable? _____

Does it bother you to cry in front of others? _____

Do public restrooms bother you? _____

Why? _____

Do you consider yourself shy or out going? _____

History form page 4

If you had to use 3 words to describe your inner self, what would they be? _____

When did your present symptoms begin and was there a stressful situation going on at the time? _____

Is your present stress level high or low? _____

Do you have difficulty expressing your feelings? _____

Are you sensitive to criticism _____

Have you ever had a bad reaction to a vaccination/shot? _____

Have you been bitten by an animal? Was the skin broken? _____

Please list any symptoms you have or have had:

Head injuries:___ Headaches:___ Face twitches:___

Neuralgias:_____ Acne:_____ Ear infections:___

Hearing Loss:___ Sensitive hearing: _____

Cold sores___ Cracks on lips___ Chancre sores___

Chapped lips: _____ Tight neck and shoulders: _____

Spinal injuries: _____ Spinal curvature:_____

Sinusitis: _____ Congestions: _____ Allergies: _____

Sneezing: _____ Chest pain/ tightness: _____

Back injuries: _____

Tooth decay: _____ Sensitivity: _____

Frequent sore throats/ Strep: _____ Tonsillitis: _____

Hoarseness: _____ Thyroid imbalance: _____

Breast pain: _____ Cancer: _____ Lumps: _____

Swelling: _____

Abdominal cramps:_____ Constipation:_____

Diarrhea: _____

Urinary tract infections: _____ Blood in urine: _____

Kidney infections: _____ Pneumonias: _____ Bronchitis: _____

Asthma: _____ Heart attacks: _____ Murmurs: _____

Racing: _____ Pounding: _____

