Wellness For ALL Walks of Life!™

Alternative Health & Wellness Center
Jacqueline A. Doval, MS

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CLIENT HISTORY

Name: ______________________________ Today's date: ____________

Occupation: __________________________ Date of birth: ____________

Address: ____

____

Mobile: _______________________ Home: _______________________

Work: ________________________

Email: ____

Male □ Female □ Are you pregnant? N □ Y □ Weeks _________

Right-handed □ Left-handed □ Ambidextrous □

Height ____________ Weight ______________

Emergency Contact

Name: _____________________________ Phone ___________________

Family History

Relationship status: Single □ Spouse/Partner □ Name ________________

Siblings: N □ Y □ Number ___ Names ___________________________

____

Children: N □ Y □ Number ___ Names ___________________________

____

List any known health conditions that run in your family:

____

Last Name ______________________ First Name ______________________ Date ______________

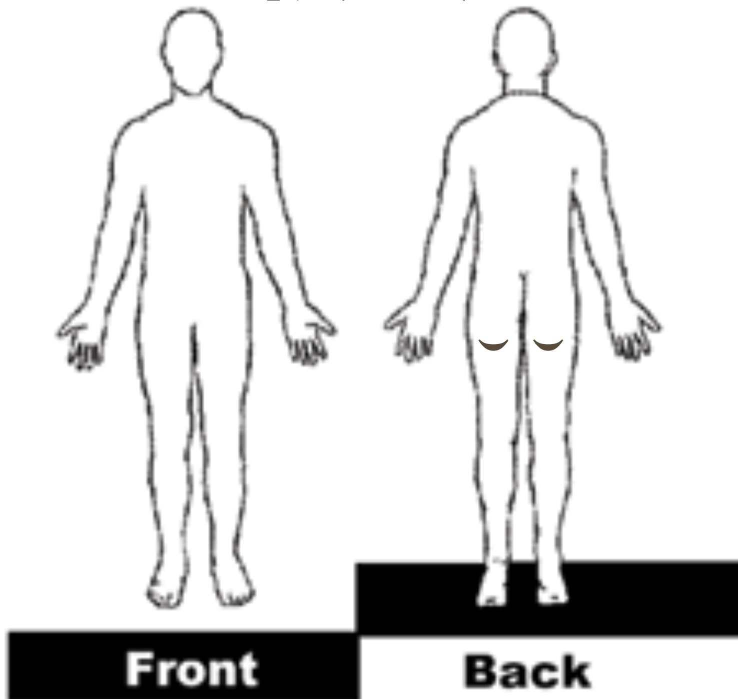
Medical History

Any problems with or changes in:	Yes	Dates and Details
Headaches / Migraines / Dizziness	☐	______________
Heart / Chest / Lungs	☐	______________
Blood pressure (high or low)	☐	______________
Poor circulation (numbness/tingling)	☐	______________
Swollen Feet / Varicose Veins	☐	______________
Eyes / Vision	☐	______________
Depression / Anxiety / Stress	☐	______________
Sleeping Difficulty / Tiredness / Fatigue	☐	______________
Blood Sugar Issues	☐	______________
Dizziness / Fainting	☐	______________
Mouth / Teeth / Gums / Tongue	☐	______________
Digestive / Gastrointestinal Issues	☐	______________
Hormonal Issues (thyroid, etc.)	☐	______________
Hair	☐	______________
Genito-Urinary Issues	☐	______________
Skin Conditions	☐	______________
Bacterial / Viral Infections (warts, athletes foot)	☐	______________
Regular Colds and Flu / Nose / Throat	☐	______________
Mental Issues	☐	______________
Epilepsy / Nerves	☐	______________
Cancer	☐	______________
Other: ______________	☐	______________
Other: ______________	☐	______________

Physical Pain / Discomfort

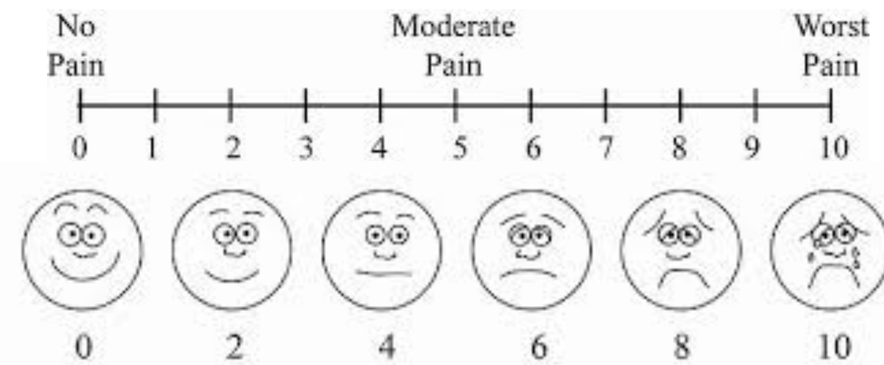
Last Name ______________________________ First Name ______________________ Date _____________

Please **mark on the drawings**, any areas of pain or discomfort.



Do you consider your pain **Chronic** (ongoing) □ or **Acute** (recent) □?

Please indicate (mark an "X" or circle) your **overall level of pain** below:



How does this affect your:

Activities of Daily Living? ____

Work? ____

Social Activities? ____

____

____

____

Traumas

Last Name ______________________ First Name ______________________ Date ____________

Accidents / Fractures / Closed Head Injuries ______________________________

____

Surgery ____

____

Childhood Illnesses ____

____

Other Treatments and Outcomes ______________________________

Medications

Medications ____

Supplements ____

Sleep

Do you sleep on your? Side ☐ Back ☐ Stomach ☐

Do you use a pillow? under head ☐ behind neck ☐ under legs or knees ☐ between legs ☐

Do you nap? N ☐ Y ☐ Regularly ☐ Occasionally ☐ Total sleep hours _______?

Diet and Lifestyle

Do you use / consume an of the following?

Tobacco:	☐ never	☐ occasionally	☐ frequently	Qty: _______/day
Sodas:	☐ never	☐ occasionally	☐ frequently	Qty: _______/day
Energy drinks:	☐ never	☐ occasionally	☐ frequently	Qty: _______/day
Coffee:	☐ never	☐ occasionally	☐ frequently	Qty: _______/day
Tea:	☐ never	☐ occasionally	☐ frequently	Qty: _______/day
Alcohol:	☐ never	☐ occasionally	☐ frequently	Qty: _______/day
Recreational drugs:	☐ never	☐ occasionally	☐ frequently	Qty: _______/day

Last Name ____________________________________ First Name ___________________________ Date ________________

What might you eat on a typical day? (Also approximate quantity.)

Breakfast ____

a.m. snack ____

Lunch ____

p.m. snack ____

Dinner ____

late snack ____

other ____

Exercise

Are you currently on an exercise program? N ☐ Y ☐ Times ______/week

Which exercises do you enjoy? ____

Goals

(1) ____

(2) ____

(3) ____

For DocJackie:

Client Acknowledgement and Consent

□ I acknowledge that:

- DocJackie is not qualified to carry out a medical examination, and I agree not to interpret her comments as medical advice.
- DocJackie is not qualified to provide a diagnosis, and I will not consider any advice given as such.
- DocJackie is not qualified to provide any natural remedy advice. Any guidance provided is based on direct bio-feedback obtained from the client's mind-body during the session.
- I have stated all my known medical conditions and answered all questions honestly. I also agree to her updated of any changes in my conditions.
- A DocJackie session, in rare cases, could lead to a temporary feeling of light-headedness, energy or emotional highs and lows, achy joints and/or sore muscles.
- I understand this service is not covered by insurance.

□ I understand and accept the following booking and payment terms:

- Appointments cancelled less than 24 hours from the time of the appointment will incur a charge of 50% of the full consultation fee.
- Consultation fees must be paid at the time of the consultation, and can be by cash, check or credit card.

Client Signature ____

Printed Name ____

Date ________________________

How did you hear about DocJackie?

Word of mouth □ Search engine □ Street presence □ Mobile / Show □

Referral □ Referred by: ____