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Wholistic Health Record - Adult

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Gender or Orientation: _____

Address: _____ City _____ State: _____ Zip: _____

Occupation: _____ Name of Employer: _____

Marital Status: _____ If married, Name of Spouse: _____

I Authorize Blue Spark Health, PLLC to contact me at the following:

Phone: _____ Phone: _____

Preferred email address: _____

Whom may we thank for referring you to Blue Spark Health? _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number (s): _____ / _____

Name of Primary Care Doctor: _____

Names of Specialists: _____

SYMPTOM SURVEY

Name: _____ Date: _____

What are your 3 primary health concerns/health goals in order of importance?

1. _____

2. _____

3. _____

Have you received other treatment for these conditions? If Yes, what, when, where?

What are your hopes and expectations from treatment with Dr. Phillips?

Did you know that energy medicine can provide profound healing?

If you could wave a magic wand what would you change about your health?

PLEASE CHECK AND/OR CIRCLE ANY SYMPTOMS THAT APPLY TO YOU ON THE FOLLOWING PAGES

NOW	PAST	GENERAL SYMPTOMS	NOW	PAST	EYES
		Tired, weak, lack of energy			nearsightedness or farsightedness
		Depression, melancholy, moodiness			Blurred or failing vision
		Worry, anxiety, nervousness, irritability			Dry, burning or itching eyes
		Difficulty with sleep			Eyes water excessively
		Frequent colds or other illness			Eyes sensitive to light
		Headaches			Night blindness
		Don't sweat enough			Bloodshot or puffy eyes
		Sweat too much	<u>Other:</u>		
		Night sweats	NOW	PAST	EARS
		Dizziness, fainting, convulsions			Earaches
		Loss or gain of weight			Noises or ringing in ears
					Ear discharges
<u>Other:</u>					Loss of hearing
NOW	PAST	SKIN AND HAIR			Lots of wax
		Acne or pimples			
		Skin rashes	<u>Other:</u>		
		Hives	NOW	PAST	MOUTH, NOSE AND THROAT
		Stretch marks			Hay fever, sinusitis, runny nose
		Skin ulcers or sores			Cracks in corners of mouth
		Dryness, roughness or scaling skin			Dry mouth
		Hair loss or thinning			Stuffy nose
		Dry, coarse hair or split ends			Clear throat often
		Bruise easily			Sore, red or cracked tongue
		Nails weak, ridged or split easily			Cold sores or herpes
		Brown spots or bronzing skin			Inability to smell or taste
		Moles, warts, or skin tags			Nose bleeds
		Sunburn easily			Bleeding gums
		Cuts heal slowly or scar badly			Hoarseness
		Flush easily			Sore throats or tonsillitis
		Feet burn			Lot of cavities
		Athletes foot			Amalgam fillings
<u>Other:</u>					Root canals
NOW	PAST	RESPIRATORY	<u>Other:</u>		
		Spitting up mucus or blood	NOW	PAST	MUSCULO-SKELETAL
		Difficulty breathing			Muscle pain or stiffness
		Shortness of breath on exertion			Where? _____
		Shortness of breath laying flat			Swollen, painful, or stiff joints
					Bone pains
<u>Other:</u>					Painful feet, ankles or calves

NOW	PAST	GASTROINTESTINAL	NOW	PAST	MUSCULO-SKELETAL
		Loss of appetite			Tremor or twitches
		Excessive appetite			Hernia
		Gagging, difficulty swallowing			Muscle wasting
		Nausea or vomiting			Hands or feet numb or tingling
		Bad breath	<u>Other:</u>		
		Metallic or bitter taste in mouth	NOW	PAST	CARDIOVASCULAR
		Food cravings or strong desires			Heart beats fast or irregularly
		Can't eat fats			Tightness in chest
		Heartburn			Dizzy or weak upon standing up
		Indigestion or distress			Swollen feet, ankles or legs
		Heaviness after eating			Discomfort at high altitude
		Belching or gas			Cold hands or feet
		Bloating			Hands or feet turn blue
		Stomach or abdomen tender or painful			Blue fingernails
		Symptoms relieved after eating			Leg pains when walking
		Symptoms worse after eating			Varicose veins
		Avoid certain foods			Tendency to anemia
		If you skip a meal do you experience:			High blood pressure
		Headache			Low blood pressure
		Irritability or anxiety	<u>Other:</u>		
		Dizziness or fatigue			
		Diarrhea or loose stools	NOW	PAST	URINARY
		Constipation			Difficulty urination
		Change in bowel movements			Urinate frequently at night
		Light colored or greasy stools			Bed-wetting
		Dark stools or blood in stool			Incomplete urination or dribbling
		Feeling of incomplete evacuation			Pain when urinating
		Undigested food in stool			Bladder infections
		Foul odor of stool or gas			Kidney infections
		Hemorrhoids			Kidney stones
					Lower back pain
<u>Other:</u>			<u>Other:</u>		
NOW	PAST	MALE	NOW	PAST	MALE
		Prostate problems			Difficulty obtaining or maintaining an erection
		Difficult or unusual urination	<u>Other:</u>		
		Discomfort or pain in genital area			
		Diminished sexual desire			
		Excessive sexual desire			

NOW	PAST	FEMALE	NOW	PAST	FEMALE
		Irregular menstruation			Hot flashes
		Pain prior to or on periods			Diminished sexual desire
		Depressed or irritable around periods			Excessive sexual desire
		Painful or swollen breasts			Difficulty having orgasm
		Lumps in breasts			Inability to conceive
		Discharge from breasts			Number of pregnancies
		Do symptoms occur monthly? ○ NO ○ YES			Miscarriages or abortions
		Pain discomfort or itching in genital area	<u>Other:</u>		
		Vaginal discharge			

Date of last period _____ Number of days _____ Length of cycle _____
Date of last PAP smear _____ Have you ever had an abnormal PAP _____
Have you ever used birth control pills or an IUD? ○ NO ○ YES If Yes what type and for how long? _____
Current type of birth control? _____

LIFE STYLE

How do you manage stressors in your life? _____

Who else is a part of your healthcare team; massage therapist? ○ Chiropractor ○
Shamanic medicine practitioner ○ Acupuncturist ○ Therapist ○

Do you get regular exercise? Yes ○ No ○ If Yes, what type? _____ How often? _____

Do you watch television? Yes ○ No ○ If Yes, hours per day _____ Week _____

Habits:
○ Tobacco ○ Coffee ○ Tea ○ Soda ○ Alcohol ○ Cannabis ○ Drugs ○ Sugar ○ Salt ○ Other _____
How often _____

Average Daily Diet:
Morning: _____

Afternoon: _____

Evening : _____

Have you ever had your food intolerances assessed using the Carroll Food Intolerance Method?

Do you have allergies? ○ YES ○ NO

Drugs: _____

Foods: _____

Environmental: _____

PRESCRIPTION MEDICINES AND OVER – THE-COUNTER MEDICATION

Please list any medications you are currently taking
(Use back of page if necessary)

VITAMINS, MINERALS, HERBS OR ANY NATURAL SUPPLEMENTS

**Have you ever been hospitalized or had surgery, a serious illness or accident?
What? When?**

Have you or any of your family members had any of the conditions in this chart?

Please indicate who has had which problems by checking the appropriate space.

	Self	Children	Mother	Father	Sister(s)	Brother(s)	Grandparents	Other
Thyroid Problems								
Diabetes								
Tuberculosis								
Hypoglycemia								
Stroke								
Heart Attack								
Epilepsy								
Cancer								
Asthma								
Allergies								
Anemia								
Migraines								
Hepatitis								
Heart Disease								
Birth Defects								
High blood pressure								
Gallbladder Disease								
Arthritis								
Alcoholism/Addiction								