Full Spectrum Wellness

Enhancing Health and Harmony in the Body

CLIENT INFORMATION AND HEALTH HISTORY FORM

Practitioner Notes:

General Information:

Name: _____

Date: _____

Contact Phone: _____

Email: _____

Address: _____ City: _____ State: _____

Zip: _____

Date of Birth: _____.

Sex: F ☐ M ☐ Height: _____ Weight: _____

Relationship Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐

Emergency Contact Information:

Name: _____

Phone: _____

Relationship: _____

Birth History:

Were you born at home, in a hospital, or birthing center?

_____

Were you born by vaginal delivery or c-section?

_____

Did your mom have an epidural during your labor?

Yes ☐ No ☐ Unsure ☐

Was there any pain medication administered during labor?

Yes ☐ No ☐ Unsure ☐

Was the medication Pitocin used to induce labor?

Yes ☐ No ☐ Unsure ☐

Were you adopted, raised by your biological parents, or other?

_____

If other please explain:

_____

_____

_____

_____

_____

Were you nursed or bottle fed?

_____

Which state and country did you grow up in?

_____

Dental History:

Do You Have Any of The Following?

		How Many? / Date(s) of Procedure(s)
Yes ☐ No ☐	Root Canals	
Yes ☐ No ☐	Crowns	
Yes ☐ No ☐	Implants	
Yes ☐ No ☐	Dentures	
Yes ☐ No ☐	Braces	
Yes ☐ No ☐	Mercury (Amalgam) Fillings	

Health History:

Health of Mom:

_____

_____

Health of Dad:

_____

_____

How many siblings do you have? _____ What Number Are You In Birth Order? _____

List Childhood Traumas:

_____

_____

_____

_____

_____

List Adult Traumas:

_____

_____

_____

_____

_____

Right or Left-Handed? R ☐ L ☐ | Are You Pregnant? Yes ☐ No ☐ | Due Date: _____

Number of Children and Their Ages:

_____

Have you had any abortions: Yes ☐ No ☐ | How many? :_____

Have you had any miscarriages: Yes ☐ No ☐ | How many? : _____

Have you had any of your children die? : Yes ☐ No ☐

Were Your Children Born By Vaginal Delivery Or C Section? : _____

Were There Any Medications Administered During Labor? : Yes ☐ No ☐

If Yes, Please List Which Ones:

_____

_____

_____

_____

Did You Nurse, Or Are You Currently Nursing? : Yes ☐ No ☐

Occupation: _____ Do You Enjoy Your Job? Yes ☐ No ☐

Blood Type: _____ Have You Been Vaccinated? Yes ☐ No ☐

If Yes, Provide the Date(s) For The Corresponding Vaccinations:

Flu Vaccine: _____

Shingles: _____

Gardasil: _____

Pfizer: _____

Astrazeneca: _____

Hn1: _____

Moderna: _____

Covid:_____

Which Of The Following Have You Lived Near?

Powerline(s): ☐ How Long and When: _____

Chemical Plant(s): ☐ How Long and When: _____

Airport: ☐ How Long And When: _____

Do You Have A Regular Bowel Movement Before Noon Each Day? Yes: ☐ No: ☐
Two Or More Per Day?: Yes: ☐ No: ☐

Constipated?: Yes ☐ No ☐ Diarrhea?: Yes ☐ No ☐

Do You Feel Rested?: Yes ☐ No ☐

How Much Sleep Do You Get Per Night? _____(hrs)

What Time Do You Normally Go To Bed? _____

Do You Wake Up in The Night?: Yes ☐ No ☐ Sometimes ☐

What Time(s)? _____

How Often? _____

Do You Wake Up To Go To The Bathroom?: Yes ☐ No ☐ Sometimes ☐

Do You Feel Stressed?: Yes ☐ No ☐ Sometimes ☐

What Causes Most Of Your Stress?

_____

_____

_____

What do you do when you are stressed?

_____

_____

_____

Do you feel you have an outlet or a way to relieve stress, and what is it?

_____

_____

_____

Describe Your Energy Level:

_____

_____

_____

Do You Exercise?: Yes ☐ No ☐

How often and what form of exercise?

_____

_____

_____

Are you currently seeing a medical doctor for any reason?: Yes ☐ No ☐

If Yes, Please Explain:

_____

_____

_____

_____

_____

Please List any Surgeries you Have Had:

Surgery	*Month/Year*	*Purpose*

Are you Currently Taking Any Medication?

Medication	*Date Prescribed*	*Purpose*

Please List 5 Main Health Concerns You Have in Order of Importance

(1 Being Most Important; 5 Being Least Important)

1. _____

2. _____

3. _____

4. _____

5. _____

Have You Ever Been Diagnosed By A Medical Doctor Or Feel You May Have Any Of The Following? (Please List Month And Year.)

		Explanation	Month/ Year
Yes ☐ No ☐	Adhd		
Yes ☐ No ☐	Aids/Hiv		
Yes ☐ No ☐	Alcoholism		
Yes ☐ No ☐	Allergies		
Yes ☐ No ☐	Anemia		
Yes ☐ No ☐	Appendicitis		
Yes ☐ No ☐	Arteriosclerosis		
Yes ☐ No ☐	Asthma		
Yes ☐ No ☐	Blood Pressure		

Yes ☐ No ☐	Breathing Problems		
Yes ☐ No ☐	Bursitis		
Yes ☐ No ☐	Cancer		
Yes ☐ No ☐	Cholesterol		
Yes ☐ No ☐	Colitis		
Yes ☐ No ☐	Constipation		
Yes ☐ No ☐	Crohn's		
Yes ☐ No ☐	Depression		
Yes ☐ No ☐	Diabetes		
Yes ☐ No ☐	Diverticulitis		

Yes ☐ No ☐	Diverticulosis		
Yes ☐ No ☐	Eczema		
Yes ☐ No ☐	Edema		
Yes ☐ No ☐	Emphysema		
Yes ☐ No ☐	Epilepsy		
Yes ☐ No ☐	Fibrocystic Breast Disease		
Yes ☐ No ☐	Fibromyalgia		
Yes ☐ No ☐	Fluid Retention		
Yes ☐ No ☐	Gallbladder		
Yes ☐ No ☐	Goiter		

Yes ☐ No ☐	Gout		
Yes ☐ No ☐	Headaches/Migraines		
Yes ☐ No ☐	Heart Disease		
Yes ☐ No ☐	Hypoglycemia		
Yes ☐ No ☐	Influenza		
Yes ☐ No ☐	Joint Aches		
Yes ☐ No ☐	Kidney Problems		
Yes ☐ No ☐	Lyme		
Yes ☐ No ☐	Measles		
Yes ☐ No ☐	Multiple Sclerosis		

Yes ☐ No ☐	*Mumps*		
Yes ☐ No ☐	*Neuralgia*		
Yes ☐ No ☐	*Nervous Tension*		
Yes ☐ No ☐	*Night Sweats*		
Yes ☐ No ☐	*Numbness*		
Yes ☐ No ☐	*Pleurisy*		
Yes ☐ No ☐	*Penumonia*		
Yes ☐ No ☐	*Polio*		
Yes ☐ No ☐	*Rheumatic Fever*		
Yes ☐ No ☐	*Scarlet Fever*		

Yes ☐ No ☐	Skin Problems		
Yes ☐ No ☐	Stroke		
Yes ☐ No ☐	Thyroid		
Yes ☐ No ☐	Tuberculosis		
Yes ☐ No ☐	Ulcers		
Yes ☐ No ☐	Varicose Veins		
Yes ☐ No ☐	Venereal Disease		
Yes ☐ No ☐	Whooping Cough		

WOMEN ONLY

Date Of Your First Menstrual Cycle: _____

		Explanation	*Month/Year*
Yes ☐ No ☐	*Ablation*		
Yes ☐ No ☐	*Abortion*		
Yes ☐ No ☐	*Birth Control*		
Yes ☐ No ☐	*Hormone Therapy*		
Yes ☐ No ☐	*Hot Flashes*		
Yes ☐ No ☐	*Hysterectomy*		
Yes ☐ No ☐	*Infertility*		

Yes ☐ *No ☐*	*Menopause*		
Yes ☐ *No ☐*	*Menstrual Cramps*		
Yes ☐ *No ☐*	*Miscarriage*		
Yes ☐ *No ☐*	*Mood Swings*		
Yes ☐ *No ☐*	*Premenstrual Syndrome*		

Food and Beverage Consumption

*List The Three **Worst** Foods You Eat During The Average Week:*

1. _____

2. _____

3. _____

*List The Three **Healthiest** Foods You Eat During The Average Week:*

1. _____

2. _____

3. _____

Do You Smoke: Yes ☐ No ☐ | Times Per Day/Week: _____

Approximately How Much Water Do You Drink A Day? _____

Distilled: ☐ Reverse Osmosis: ☐ Spring: ☐ City Tap: ☐ Well: ☐

How many of these beverages do you consume per day?

Coffee: ☐ Sweet Tea: ☐

Green Tea: ☐ Energy Drinks: ☐

Black Tea: ☐ Bottled Juice: ☐

Soda: ☐ Herbal Tea: ☐

Do You Use A Juicer? Yes ☐ No ☐

If Yes: Vita Mix Or Extractor? _____ How many times per week? _____

How many alcoholic beverages do you consume per week?

_____

What type of alcohol do you consume (beer, wine, etc.)?

_____

How many times do you eat out per week?

_____

How many times do you eat fish per week?

_____

How many times do you eat raw nuts or seeds per week? _____

Please list any natural supplements you currently take, the purpose of the supplement, and the date you started taking it.

Supplement	*Purpose*	*Date*

How did you hear about Full Spectrum Wellness? _____

Please take time and use this page to tell me your story.

You may write on additional pages if necessary. Write whatever you think will help me understand where you are in your pursuit of wellness.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Preparation For Your Visit and The Spectravision Scan

The Spectra Vision will be evaluating the responses of the body to the various digital signals and their relationship to overall balance and energy flow. This process is called "BioEnergy Balancing" and is designed to assess impedances within the BioNet of the body. The BioNet is the electrical aspect of the body that lies within the connective tissues.

1. Please keep a three-day food log and bring it to your first appointment. Be honest and record everything you eat and drink.

2. Stop taking all supplements 24 hours before your visit. Continue prescriptions.

3. No alcohol or caffeine within 12 hours of testing.

4. Do not eat at least 2 hours before your appointment.

5. Make sure you are well hydrated by drinking ½ your weight in ounces the day before, and the day of, your appointment. This is a good rule of thumb for everyday life.

6. No exercise the day of the appointment. Get a solid 8 hours of sleep. You should be well rested for your test.

7. Bring any supplements to your appointment that you take on a regular basis, so we can test them to see if they are keeping your body in balance.

8. A low-level laser will be used. Please do not wear black or dark clothing. Please wear a white or light-colored shirt to your appointment.

Contraindications

The Spectra Vision Will NOT Be Used If:

1. Subcutaneous TENS units – must be able to deactivate the unit so it doesn't interfere with the MC Scan or SC testing.
2. You are pregnant.
3. You have a pacemaker.
4. You have had an organ transplant and are on Immuno-Sup drugs.
5. You have seizures.
6. You have shunts or stints of any kind.
7. You have been electrocuted or struck by lightning.
8. It is okay if you have metal plates, pins, rods, and/or denture implants.

***Disclaimer**: Dr. Allen's intention is to reeducate and assist with natural health information for the sole purpose of suggestion. You are responsible to research for yourself and choose the way you desire to live. This health history form is not intended to diagnose, prescribe, or treat any illness.*

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We look forward to having you!