Nalu Way

CONNECT. MOVE. HEAL. FLOW

GRACE SUNDMAN, LMT, HOLISTIC COACH

Personal information			
Name:		DOB:	
Cell Phone:			
Email Address:			
Emergency Contact:			
Date of First Visit:			
Referred By:			

Chief complaint	
Your primary goal for this visit?	
Where is the discomfort?	
When did it start?	
What induced the problem?	
When does it bother you the most?	
Severity (0-10, 10 being most severe)	
What makes it worse?	
What makes it better?	
Have you seen an MD for this?	
Did you get a diagnosis from the MD?	
Have you seen anyone else for this?	

Hospitalizations, Surgeries (including Plastic, Dental…), Injuries (skip if doesn't apply, add lines if needed)		
	Type of Operation or Illness:	Date
1.		
2.		
3.		
4.		
5.		

Personal Health History:	Check Y/N		Check Y/N
Artificial Joints:		Arthritis:	
Sprains/Strains:		Diabetes:	
Allergies/Sensitivity:		Asthma:	
Intestinal Problems:		Circulatory Problems	
High Blood Pressure:		TMJ/ Mouth Guard:	
Varicose Veins:		Vision (Contacts/Glasses):	
Frequent Urination:		Anxiety/Depression	
Tinnitus:		Orthotics	
Sleep Problems:		Bruise Easily:	
Headaches:		Low Energy/Fatigue:	

Please elaborate on any affirmative answers given above:

List any medications you are currently taking (Skip if doesn't apply, add lines if needed)		
Name of medication	**Dosage/day**	**Reason for taking? Taking since?**

Lifestyle information	
How frequently do you exercise?	
What kind of exercise?	
Do You have trouble Sleeping?	
Do you Smoke?	

List All Scars (surgical, laparoscoptic, mole removal, burns, injuries…):
Head Trauma (Falls, Car/Bike Accidents):

Please return the completed form to graceflow13@gmail.com
within 24 hours of your scheduled appointment. Thank you!