



ACT Approved Health  
complete and return

Please print

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

email: \_\_\_\_\_

Phone: \_\_\_\_\_

Married? Y N Divorced? Y N

# of Children? \_\_\_\_\_

Your Age? \_\_\_\_\_ Sex? M F

Check what applies about your  
Childhood with: Dad Mom

Loving?.....  
Great? .....  
Sickly? .....  
Depressed? .....  
Alcoholic? .....  
Drug? .....  
Distant? .....  
Angry? .....  
Screamer? .....  
Critical? .....  
Physical Abuse?...  
Sex Abuse?.....  
Left Completely?...  
Died? .....  
Didn't Protect Me? .....

Medical Diagnoses

Childhood Disease

1. \_\_\_\_\_  
2. \_\_\_\_\_

Please List Your Top 3 Traumas:

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

What ages were you when these came on? →

			Week 1		Week 2	
			INTENSITY	FREQUENCY	INTENSITY	FREQUENCY
1						
2						
3						
4						
5						
6						
7						

Were there notable circumstances around the time of the symptoms - ie: divorce, death, break ups, accidents, etc

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# ACT Approved Health Form Part 2

I am adopted Y N \_\_\_\_\_  
 I've had Blood Transfusion or Organ Transplant \_\_\_\_\_  
 My Brain races at night Y N \_\_\_\_\_  
 I Sleep Good/Poorly \_\_\_\_\_  
 I Wake Up Refreshed Y N \_\_\_\_\_  
 I Wake Up Stiff Y N (if Yes, circle what is stiff)  
 Shoulders Elbows Hands Hips Legs Calves Feet \_\_\_\_\_  
 I Crash Daily Y N \_\_\_\_\_  
 My Herx's are **very serious** Y N \_\_\_\_\_  
 I've done recreational drugs? Y N pot only, \_\_\_\_\_  
 Spiritual Beliefs: God exists? Y N not sure \_\_\_\_\_

Please print

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Things you think I should know about you.

\_\_\_\_\_

List allergies and how you react:

\_\_\_\_\_

\_\_\_\_\_

Surgeries? \_\_\_\_\_

List any 'living creatures' Drs. have found in you

\_\_\_\_\_

Been ill in a foreign country? Y N Where? With w

\_\_\_\_\_

**Emotionally, I suffer from:**

Panic Attacks Y N Depression Y N hat  
 Anxiety Y N Suicidal thoughts Y N

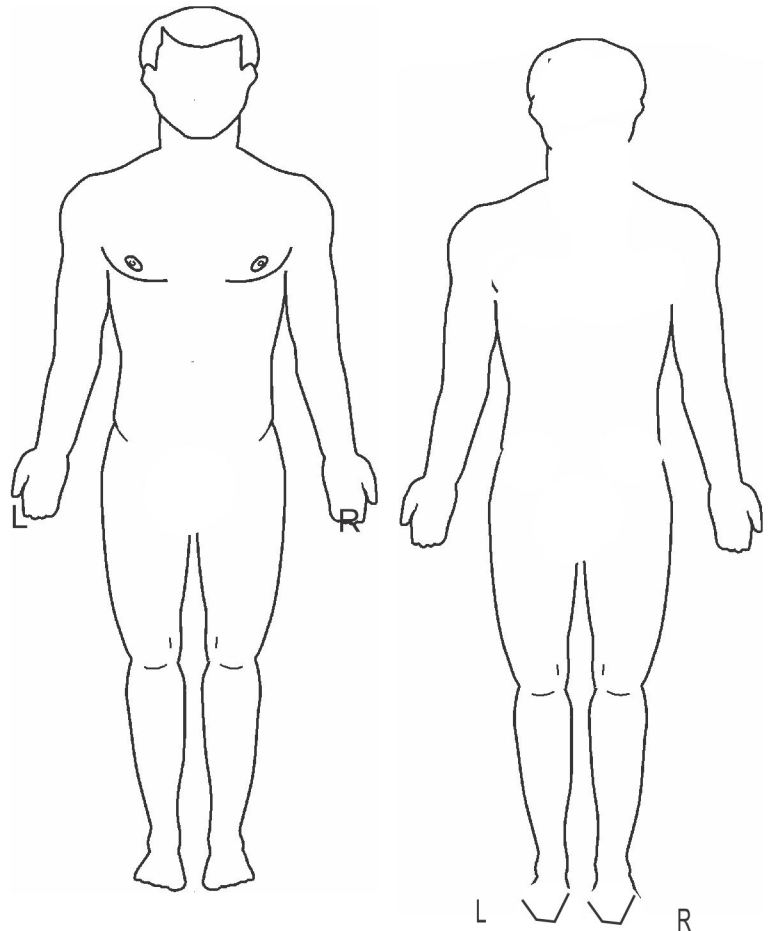
Any notable medical drug reaction? \_\_\_\_\_

Which drug? What happened?

**Rate your "Wellness Quotient": Rate** \_\_\_\_\_

Let's say prior to getting ill you were 100% well. G  
 your current functionality, energy level, and emotio  
 state, how would you rate your "Wellness" this mo  
 20% 30% 40% 50% 60% 70% 80% 90%

**Fill out diagram for your conditions:** Itch (i) \_\_\_\_\_ %  
 Indicate Burning (B), Tingling (T), Joint Pain (JP), nal  
 Pressure (P), Muscle Pain (MP) and anything else nth?  
 Draw a jagged line for traveling pains. ?



**Medications?/ For?**


**What other modalities have  
you tried or are using?**
