Dawne Horizons
SPA & WELLNESS CENTER, LLC

www.dawne-horizons.com **571-357-0562** **askdawne@dawne-horizons.com**

Health Assessment Sheet

1. Do you have any Allergies? Please list: _____
_____
2. Do you have any Transplant Organs or Pacemaker?
3. Have you had any Surgeries? Please list:
_____
4. Are you Pregnant? Yes ____ No____
5. Do you have Seizures or Have you ever had a Seizure? Yes ____ No_____ When? _____
6. Do you smoke? Yes____ No____ Do you drink? Yes___ No___ How often? _____
7. Are you on Dialysis? Yes ____ NO_____ Have you ever been on Dialysis? Yes____ No ____
8. What does your diet mainly consist of? Please list: _____
_____
9. Are you willing to change your diet to improve your health concerns? Yes ____ No _____
10. Are you on any medications? Please list: _____
_____

11. Do you take Vitamins or Nutritional Supplements? Yes ____ No_____ Please list: _____
_____

12. Do you feel the Medications and/or Vitamins are helping you? Yes ___ No___ If so, how?
If not, why? _____
13. What ailments, illnesses or health concerns do you have? Please list: _____
_____

Family History*: Please state when diagnosed and/or how long you have had it on the bottom.

Please indicate S for Self, M for Mother or F for Father

- Acid Reflux
- Allergies
- Anemia
- Asthma
- Blood Pressure (Hi or Low)
- Cancer
  Type: _____
  Location: _____
- Constipation or Diarrhea
- Depression
- Diabetes Type I or II
- Dizziness
- Eczema
- Fatigue
- Fibroids
- Fibromyalgia
- Heart Attack
- Heart Disease
- Irritable Bowel Syndrome
- Gall Stones
- Gas/Bloating
- Headaches/Migraines
- Kidney Stones
- Kidney Failure
- Low Back Pain
- Overweight
- Obesity
- PMS
- Prostate Problems
- Reproductive Problems
- Stroke
- Ulcer
- Cholesterol (Hi or Low)
- Other:
  _____

**All information is kept Strictly Confidential*

Next Step: Plan your Discovery Call w/Dawne
https://calendly.com/dawnehorizons/15min