DATE _____

MARYLANGFIELD Health History Form

CONTACT

Name _____
Address _____
_____
Phone: day _____ night _____
Email _____
Referred by _____
If not referred, how did you hear about me? _____
Sign up for newsletter ☐ yes ☐ no
Age _____ Birthdate _____
Place of birth _____
Gender _____ Height _____
Blood type _____ Birth weight _____
Current weight _____ Weight 6 months ago _____
Weight 1 year ago _____
Would you like your weight to be different? _____
If so, what: _____
Relationship status/living situation: ☐ single ☐ married
☐ divorced ☐ separated ☐ widowed ☐ other

Children _____
Pets _____
Education (YRS. COMPLETED): ELEM _____ HS _____
COLL _____ VOC _____ PROF _____
Occupation _____
Retired ☐ yes ☐ no
Hours of work per week _____
How much time have you had to take off from work/school in the last year? _____
Number of days _____
I find my work: ☐ satisfactory ☐ very satisfactory ☐ too demanding ☐ boring
What kind of exercise/recreation do you participate in? _____
_____
_____
Frequency and exertion level of exercise/recreation _____
_____
_____

RESPONSIBLE PARTY (☐ CHECK IF SAME AS ABOVE)

Name _____
Address _____
Phone: day _____ night _____

EMERGENCY CONTACTS

1
Name _____
Address _____
Phone _____ Relationship _____

2
Name _____
Address _____
Phone _____ Relationship _____

All information shared will be kept confidential.

MARYLANGFIELD Health History Form

MY HEALTH CONCERNS

Please list your main health concerns at this time: _____

_____

_____

_____

When did you first experience these concerns? _____

_____

_____

_____

How have you dealt with these issues in the past? _____

_____

○ Doctors (CHECK BOX) ○ Self Care (CHECK BOX) ○ Alternative Therapies (CHECK BOX)

○ Other (CHECK AND EXPLAIN) _____

HISTORY

Have you lived or traveled abroad? ☐ yes ☐ no

If so, where and when? _____

Have you ever experienced any major life changes? _____

Please explain _____

Have you ever been arrested? ☐ yes ☐ no

Please explain _____

Have you ever been incarcerated? ☐ yes ☐ no

Please explain _____

Have you been in the military service? ☐ yes ☐ no

Please explain _____

Have you had any major losses in your life? _____

Please explain _____

Do you love and accept yourself for who you are? _____

How does this question make you feel? _____

Have you ever been a victim of abuse? ☐ physical ☐ sexual ☐ emotional ☐ N/A

Please explain _____

All information shared will be kept confidential.

HISTORY (CONT.)

What other health practitioners are you currently seeing? (PLEASE PROVIDE NAME, SPECIALTY AND PHONE #) _____

_____

_____

Do you have family members with similar health challenges? _____

Please explain _____

How frequently do you take antibiotics? _____

Please list any medicines you are currently taking: _____

_____

Please list all nutritional supplements you are currently taking, (E.G. VITAMINS, MINERALS, HERBS, ESSENTIAL OILS, ETC): _____

_____

_____

Do you avoid certain foods because of how they make you feel? _____

If yes, please name foods and symptoms _____

_____

Are you a fast or slow eater? _____

Are you a stress or emotional eater? _____

Do you have any physical symptoms immediately after eating such as bloating, gas or hives? _____

If yes, please explain _____

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion? ___

If yes, please explain _____

Do you have food cravings? _____

What for and when? _____

Please describe your diet at the onset of your health concerns: _____

_____

Do you have any known food sensitivities/allergies? _____

Do you consume any of these regularly:

- ☐ Alcohol
- ☐ Refined sugar
- ☐ Soda
- ☐ Diet soda
- ☐ Coffee
- ☐ Fast food
- ☐ Microwavable foods
- ☐ Gluten (WHEAT, RYE, BARLEY)
- ☐ Dairy (MILK, CHEESE, YOGURT)

Are you on a special diet? _____

- ☐ Vegetarian
- ☐ Vegan
- ☐ Paleo
- ☐ Gluten free
- ☐ Refined sugar free
- ☐ Raw
- ☐ Blood type
- ☐ Dairy free
- ☐ Diabetic
- ☐ Keto
- ☐ Other (PLEASE EXPLAIN) _____

_____

What percentage of your food is home cooked? _____

What else should I know about your current diet, history or relationship to food? _____

_____

All information shared will be kept confidential.

MARYLANGFIELD Health History Form

FAMILY HISTORY

☐ *Check if family history is unknown.* ** Maternal Grandfather, Maternal Grandmother, Paternal Grandfather, Paternal Grandmother*

	AGE	IF DECEASED, CAUSE OF DEATH	CHILDREN	AGE	PROBLEMS
MAT GF*					
MAT GM*					
PAT GF*					
PAT GM*					
FATHER					
MOTHER					
SIBLINGS					

Check items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

YES		RELATIONSHIP	YES		RELATIONSHIP
☐	Alcohol/drug problem		☐	High blood pressure	
☐	Allergy/asthma		☐	High cholesterol/fat	
☐	Anemia		☐	Kidney disease	
☐	Arteriosclerosis		☐	Liver disease	
☐	Arthritis		☐	Mental illness	
☐	Binge eating/bulimia		☐	Obesity	
☐	Cancer		☐	Stroke	
☐	Diabetes		☐	Suicide	
☐	Epilepsy/seizure		☐	Thyroid disease	
☐	Heart disease		☐	Tuberculosis	
☐	Skin disease		☐	Gastro intestinal disease	
☐	Endocrine/hormonal imbalance		☐	Syphilis	
			☐	Gonorrhea	

PAST HISTORY OF ILLNESS AND MEDICAL PROBLEMS

Surgery: List all surgery and approximate dates

Other hospitalizations and dates

Broken bones and/or traumatic injuries
(include all car accidents or concussions)

Current health problems
Example: High blood pressure - 10yrs.

All information shared will be kept confidential.

MARYLANGFIELD Health History Form

PAST HISTORY

Check items that apply and dates.

YES		WHEN	YES		WHEN	YES		WHEN
☐	Acne		☐	Epilepsy		☐	Panic Attacks	
☐	AIDS		☐	Epstein Barr/infectious mono		☐	Pelvic infection	
☐	Alcohol/drug problem		☐	Fibrocystic breasts		☐	Peptic ulcer	
☐	Allergies		☐	Fibroids		☐	Periodontal disease	
☐	Amalgams/silver fillings		☐	Gallbladder problem		☐	Phlebitis	
☐	Anemia		☐	Genital Warts		☐	Pneumonia	
☐	Antibiotics more than once a year		☐	Glaucoma		☐	Premenstrual tension	
			☐	Gonorrhea		☐	Prostate problem	
☐	Anorexia		☐	Gout		☐	Psychotherapy	
☐	Anxiety		☐	Hay fever		☐	Reactions to vaccinations	
☐	Arteriosclerosis		☐	Hearing problem		☐	Rheumatic fever	
☐	Arthritis		☐	Heart attack		☐	Root canal	
☐	Asthma		☐	Heart failure		☐	Scarlet fever	
☐	Back pain/strain		☐	Heart problem		☐	Sexually transmitted disease	
☐	Binge eating		☐	Hemorrhoids		☐	Sinusitis	
☐	Bladder infection		☐	Hepatitis		☐	Skin problem	
☐	Blood clots		☐	Herpes		☐	Sleep disorder	
☐	Breast lump		☐	Hiatal Hernia		☐	Stroke	
☐	Bronchitis		☐	High blood pressure		☐	Suicide attempt	
☐	Bulimia (self-induced vomiting)		☐	High cholesterol/triglycerides		☐	Syphilis	
						☐	Taken steroid (cortisone/prednisone)	
☐	Cancer		☐	Hives				
☐	Cataract		☐	Hypoglycemia		☐	Thyphoid	
☐	Chemical sensitivity		☐	Insomnia		☐	Thyroid problem	
☐	Chicken pox		☐	Kidney infection		☐	Tonsillitis	
☐	Chronic fatigue		☐	Kidney stones		☐	Tooth problem	
☐	Cholera		☐	Kidney problem		☐	Tuberculosis	
☐	Colds, frequent		☐	Liver disease		☐	Underweight	
☐	Colitis		☐	Measles		☐	Urine problem	
☐	Congenital defect		☐	Meningitis		☐	Vaginitis	
☐	Counseling		☐	Menstrual problem		☐	Venereal Disease	
☐	Depression		☐	Mental illness		☐	Violent behavior	
☐	Diabetes		☐	Migraine		☐	Vision problem	
☐	Ear infection		☐	Mumps		☐	Warts	
☐	Eczema		☐	Nervous condition		☐	Yeast Infections	
☐	Encephalitis		☐	Neurologic problem		☐	Other	
☐	Endometriosis		☐	Overweight (20 lbs)				

All information shared will be kept confidential.

REVIEW OF SYMPTOMS

Answer "yes" if you have had these symptons ***in the last 6 months.***

YES	YES	YES
☐ Chronic fatigue	☐ Ringing/buzzing in ears	☐ Sore legs/feet
☐ Mood swings	☐ Sinus trouble	☐ Color change legs/arms
☐ Chronic depression	☐ Nosebleed	☐ Difficulty swallowing
☐ Trembling episodes	☐ Sore throat	☐ Pain/discomfort when eating
☐ Light-headedness	☐ Hoarseness	☐ Bad teeth
☐ Food craving	☐ Change in voice	☐ Belching
☐ Frequent infection	☐ Dental problem	☐ Coating on tongue
☐ Night sweats	☐ Dry mouth	☐ Canker sores
☐ Swollen glands	☐ Excessive salivation	☐ Pain relieved by eating
☐ Skin rash	☐ Bleeding gums	☐ Nausea/vomiting
☐ Chills/fever	☐ Mouth breather	☐ Trouble with fried foods
☐ Change in skin/nails	☐ Chronic cough	☐ Bloating of abdomen
☐ Change in wart or mole	☐ Bloody/yellow sputum	☐ Bowel gas
☐ Abnormal bleeding/bruising	☐ Shortness of breath	☐ Diarrhea
☐ Change in hair loss/growth	☐ with exertion	☐ Constipation
☐ Irritability	☐ at night	☐ Black stool
☐ Restlessness	☐ Bronchitis	☐ Clay-colored stool
☐ Headaches	☐ Chest pain with breathing	☐ Mucus in stool
☐ Dizziness/vertigo	☐ at rest	☐ Hemorrhoids
☐ Balance problem	☐ with exertion	☐ Rectal bleeding
☐ Head injury	☐ with stress	☐ Abdominal pain
☐ Seizure/convulsion	☐ with eating	☐ Change in diet
☐ Poor memory	☐ down left arm, neck or back	☐ Pain/burning urination
☐ Difficulty concentrating	☐ accompained by nausea, sweating, anxiety	☐ Frequent urination
☐ Fainting	☐ Irregular heartbeat	☐ Urination at night
☐ Weakness	☐ Skip beats	☐ Blood in urine
☐ Numbness/tingling	☐ Palpitations	☐ Foul odor to urine
☐ Blurred vision	☐ Fast heart beat	☐ Low back pain
☐ Double vision	☐ Heart murmur	☐ Incontinence
☐ Loss of any vision	☐ Swelling feet/legs	☐ Restlessness
☐ Halos around lights	☐ Cold hands/feet	☐ Worms/parasites
☐ Excessive tearing/itching	☐ Leg cramps at night	☐ Breast fed as child
☐ Eye pain	☐ Joint pain	☐ Rapid weight gain
☐ Dark circles under eyes	☐ Pain or fatigue in legs with exercise	☐ Rapid weight loss
☐ Date of last eye exam	☐ Burning feet	☐ Other _____
☐ Loss of hearing		_____

All information shared will be kept confidential.

MARYLANGFIELD Health History Form

REVIEW OF SYMPTOMS

MEN

YES	YES	YES
☐ Enlarged prostate	☐ Dribbling after urination	☐ Problem with sexual function
☐ Decreased urine stream	☐ Pus or drainage from penis	☐ Prostate problem
☐ Unable to interrupt stream	☐ Genital swelling/rash	☐ Other _____

WOMEN

YES	YES	YES
Last menstration period _____	Number of live births _____	☐ Fibroids
Age menstration began _____	Number of abortions _____	☐ Ovarian cysts
Usual length of cycle _____	Number of miscarriages _____	☐ Vaginitis
Usual length of period _____	☐ Complication of pregnancy	☐ Pelvic infection
☐ Last menstration period _____	☐ Used birth control pills	☐ Endometriosis
☐ Change in cycle	☐ Used IUD (type:) _____	☐ Infertility
☐ Spotting between periods	☐ Premenstrual tension	☐ Hormone Therapy
☐ Discomfort with periods	☐ Vaginal discharge	☐ Problem w/sexual function
Age sexual activity began _____	☐ Painful intercourse	☐ Lump in breast
Sex Drive ☐ High ☐ Low ☐ None	☐ Vaginal itching	☐ Abnormal pap smear
Age at menopause _____	☐ Self breast examination	☐ Infertility
Number of pregnancies _____	☐ Fibrocystic breasts	Date of last pap smear _____

INTESTINAL STATUS

How frequent are your Bowel Movements? Check all that apply.

☐ More than 3x's a day ☐ 1-3 times per day ☐ Not Regular

Check any that apply to your Bowel Movements.

☐ soft & well formed	☐ diarrhea	☐ loose but not watery
☐ often floats	☐ thin, long or narrow	☐ alternating between hard and loose
☐ difficult to pass	☐ small and hard	
☐ medium brown	☐ variable	☐ Do you experience intestinal gas?
☐ very dark or black	☐ yellow, light brown	PLEASE EXPLAIN _____
☐ greenish	☐ chalky colored	_____
☐ blood is visible	☐ greasy, slimy	_____

All information shared will be kept confidential.

MARYLANGFIELD Health History Form

LIFESTYLE

Have you had periods of eating junk food, binge eating or dieting? _____

If yes, please explain _____

Have you abused alcohol, drugs, meds, tobacco or caffeine? Do you still? _____

I consider myself a ☐ non-drinker ☐ social drinker ☐ heavy drinker ☐ alcoholic ☐ recovering alcoholic

How many drinks per week? _____

I use: ☐ beer ☐ wine ☐ "hard" liquor ☐ marijuana ☐ other drugs _____

I am now or have been a smoker ☐ yes ☐ no

How many years have you smoked? _____ How much? _____ When did you quit? _____

I estimate my use of coffee: _____ cups/day decaf: _____ cups/day

How do you handle stress? _____

What is your current stress level on a scale of 1-10 (1 BEING LOW STRESS AND 10 BEING HIGH STRESS)? _____

Where is this stress stemming from? _____

What do you do for fun? _____

How do you relax? _____

Do you set goals? ☐ yes ☐ no Do you follow through on those goals? Why/why not? _____

_____

_____

SLEEP

What are your sleep patterns? _____

Can you get to sleep easily? _____

Do you stay asleep? _____

How many hours on average do you sleep? _____

Is your sleep quality good? _____

Do you sleep with the TV on? ☐ yes ☐ no

What is your sleep position? ☐ back ☐ side ☐ fetal position ☐ stomach ☐ other _____

Do you sleep covered? ☐ yes ☐ no or Do you sleep uncovered? ☐ yes ☐ no

What's your typical sleep schedule? _____

_____

_____

TOXICITY

Have you been exposed to chemicals or toxic metals (LEAD, MERCURY, ARSENIC, ALUMINUM)? _____

_____

Do smells affect you? _____

Have you been or are you currently exposed to second hand smoke? _____

Do you have any mercury amalgam tooth fillings? _____

All information shared will be kept confidential.

MENTAL HEALTH

How are your moods in general? _____

Do you experience more than you would like of anxiety? Depression? Anger? _____

_____

What is your energy level like on a daily basis? On a scale of 1-10 (1 BEING LOW AND 10 BEING OPTIMAL) _____

What do you do to increase your energy or maintain it? _____

At what point in your life did you feel best? _____

Rate your current level of satisfaction: On a scale of 1-10 (1 LOWEST/10 HIGHEST)

With school/work _____ Social life _____ Physical body _____ Mental clarity _____

Intimacy/Sex _____ Partner/Spouse _____ Self expression/Emotional sharing _____

Children _____ Parents _____ Spiritual life? _____

Who in your life is the most supportive of you making dietary changes (DOCTOR, FAMILY, FRIENDS, ETC...) _____

_____

What are your health goals and aspirations? _____

Why do you want to achieve these goals? _____

What difference will accomplishing those goals make in your life? Your health? Your relationships? Your income? _____

_____

What modalities, diets, etc have you tried? What didn't work for you and why? _____

_____

MY VITALITY

What are the top three things you'd like to accomplish in our work, and when would you like to accomplish them?

1. _____

2. _____

3. _____

On a scale of 1 to 10 (10 BEING THE MOST IMPORTANT), how important is it to you to accomplish these three goals in the next 5 months? _____

_____

Who or what do you think is your biggest obstacle in achieving your goals? _____

_____

Do you have any other commitments that would keep you from being 100% successful in accomplishing your goals? (THIS COULD BE A JOB, COMMUNITY SERVICE, BOARD MEETINGS, ETC.) _____

_____

Is there anything else I need to know that would be useful in addressing your health concerns? _____

_____

_____

_____

All information shared will be kept confidential.

CLIENT BILL OF RIGHTS

State Of Minnesota Complementary And Alternative Health Care Client Bill Of Rights

Mary Langfield LLC is a single member limited liability company formed in the State of Minnesota, located at 3541 Bloomington Ave., Minneapolis, MN 55407, 612-801-8900, owned and operated by Mary Langfield Neaton, a classical homeopath, holistic health coach and yoga teacher. Mary has a Bachelor's Degree in Communications and has completed a health coach training program at the Institute for Integrative Nutrition. She is a registered yoga teacher with Yoga Alliance, having completed a 500-hour yoga training program at Devanadi School of Yoga and Wellness. She has a certification as an Ayurvedic Specialist from the Himalayan Institute. Mary is considered an unlicensed complementary and alternative health care practitioner.

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY.

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

Mary's theoretical approach to providing services to her clients is to draw upon her experience and training in classical homeopathy, dietary theories, lifestyle management and innovative coaching methods to help clients make changes that produce positive and lasting results to their health.

Mary's fees depend on the specific program or services being provided. Prior to working with any client, Mary explains fees per unit of service and method for billing. Mary does not receive reimbursement from any insurance company or health maintenance organization. Mary does not accept Medicare, medical assistance, or general assistance medical care. Mary does not accept partial payment for services.

Services such as those provided by Mary, and other services that may be used for treating your health condition may be available in the community and you are encouraged to consult with other health care providers, including your local hospital or health care clinic for resources on the availability of these services.

Client Rights

You have the right to file a complaint with the practitioner's supervisor, if any. Mary does not have a direct supervisor.

You have the right to file a complaint with the Office of Unlicensed Complementary and Alternative Health Care Practice, P.O. Box 64882, Saint Paul, Minnesota 55164-0882 (mailing address), 651-201-3721 (phone).

You have a right to reasonable notice in changes in services or charges.

You have a right to complete and current information concerning the practitioner's assessment and recommended service to be provided, including the expected duration of the service to be provided.

You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.

Your records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client or otherwise provided by law.

You have the right to be allowed access to records and written information from records in accordance with Minnesota Statutes section 144.291 to 144.298.

You have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

You have the right to coordinated transfer when there will be a change in the provider of services.

You may refuse services or treatment at any time, unless otherwise provided by law.

You may assert these client rights without retaliation.

As a complementary and alternative health care client of Mary Langfield LLC:

☐ **I acknowledge that I have received the complementary and alternative health care client bill of rights.**

Print your full name _____ Signature (ONLINE INITIALS) _____

Today's date _____

SUBMIT (EMAIL mary@marylangfield.com)

ACKNOWLEDGMENT AND RELEASE

My attendance at any programs or sessions with Mary Langfield Neaton is my own personal choice. I understand that Mary has recommended that I inform my medical doctor or other health care providers of any changes which I make as a result of consultations with her.

I understand that Mary is not a licensed doctor, nutritionist, or dietician. I acknowledge having received a copy of the "Complementary and Alternative Health Care Client Bill of Rights" which includes a description of Mary's training and qualifications.

As part of this health consultation program, Mary may recommend natural, non-prescription, over-the-counter dietary supplements or homeopathic remedies. I understand that these are only recommendations, and it is ultimately my decision whether to take any treatment. I understand that I would have the opportunity to seek out an opinion from my doctor or other health care providers before I started taking any dietary supplements, or homeopathic remedies.

I take full responsibility for the decisions I make concerning my health, including decisions based on what I learn during my consultations with Mary. As such, I release Mary Langfield, LLC, its members, agents, officers, and assigns, including Mary Langfield Neaton, from any claims, demands, or causes of action arising out of the services provided by Mary or decisions I make based upon what I learn from her classes or programs.

Print your full name _____ Signature (ONLINE INITIALS) _____

Today's date _____

Please also view the Client Bill of Rights
SUBMIT (EMAIL mary@marylangfield.com)

All information shared will be kept confidential.