Shafaw Sanctuary of Healing Lights

Healing Renaissance Clinic

God willing, others can do what Jesus did. –Hafez

Today's Date:

Full Name:

Date of Birth:

Referred By:

Email:

Address:

City: Zip: Country:

Home Phone: Cell Phone:

Occupation: Social Security:

Married? (Yes or No) Years Together:

Children? How Many: Ages:

Divorced? Years Since:

Please List Major Issues, Complaints, Concern:

What do you love doing?

Significant Relationships?

Height: Weight: Are you subject to frequent weight changes? (Yes or No)

Are you on a diet? (Yes or No) If yes, since when?

Have you lost Weight? (Yes or No)

Do you wear glasses? (Yes or No) Contact Lenses? (Yes or No)

Do you have allergies? (Yes or No) If so explain:

Did you or will you undergo any operations? (Yes or No)

Date(s) of expected operations:

Known or suspected dis-ease(s):

Do you have any procedures planned in regards to dis-ease?

Are you on medication?: If so, please state amount and frequency.

Please make a list of supplements you are taking:

Presence/Suspicion of tumors? (Yes or No) Are you in pain? (Yes or No)

Heart condition (Yes or No) Inflammation? (Yes or No)

Do your legs feel heavy? (Yes or No) Do you heal quickly? (Yes or No)

Do you feel chilly easily? (Yes or No) Thyroid problems? (Yes or No)

Hands or feet often cold? (Yes or No)

Do you experience excessive perspiration in your feet, hands, armpits? (Yes or No)

Do you have frequent sore throat or ear/nose infections? (Yes or No)

Are you or have you experienced anxiety/Nervous breakdowns? (Yes or No)

Do you have or have you ever had:

Tuberculosis? (Yes or No) Epilepsy? (Yes or No)

Hepatic Disorder? (Yes or No) Asthma? (Yes or No)

For Women:

Are you pregnant? (Yes or No)

Do you experience painful menstrual periods? (Yes or No)

Are you in menopause? (Yes or No) Since what date?;

Hormonal problems? (Yes or No) Ovarian problems? (Yes or No)