PREMIUM

HOLISTIC MEDICAL HISTORY FORM

HAVE YOU EATEN ANY FOOD IN THE LAST 2-3 HOURS?
MEDICATIONS
ARE YOU DIABETIC?
ARE YOU ANEMIC? IF SO, ARE YOU TAKING MEDICATION FOR IT?
ARE YOU PREGNANT? HOW MANY WEEKS?
DO YOU HAVE ANY SEIZURE DISORDERS?
DO YOU HAVE ANY ALLERGIES TO OILS?

Name: DOB: Age:
Address:
Tel. Number-Home: Mobile: Work:
Email address:
Emergency contact Name: Tel:
Relationship:
Blood Sugar Level: Blood pressure:
Height: Weight: Blood Type: Ph level:

MEDICAL HISTORY

Any diseases or illnesses & Current medications?
Do you have any bleeding disorders?
Do you have any metal plates, metal rods, or pacers in your body?
Do you have any disabilities/special needs?
Do you have any hereditary/genetic diseases?
Do you have any problems with your heart?
Do you have a heart stent?
Have you had any recent surgery?
Do you have any scars/disfiguration on your body?
Do you have allergies/skin conditions/hair growth issues?
Do you have mercury tooth fillings?
Are you taking any herbal or homeopathic remedies?
Are you taking any supplements, vitamins or minerals?
Are you taking any Hormone treatments?
Are you taking any Hormonal replacement therapy?
Are you taking any steroids?
Do you take drugs? Type?
Do you smoke? How much?
Do you use a Nicotine patch, nicotine replacement treatment or Vape Therapy?

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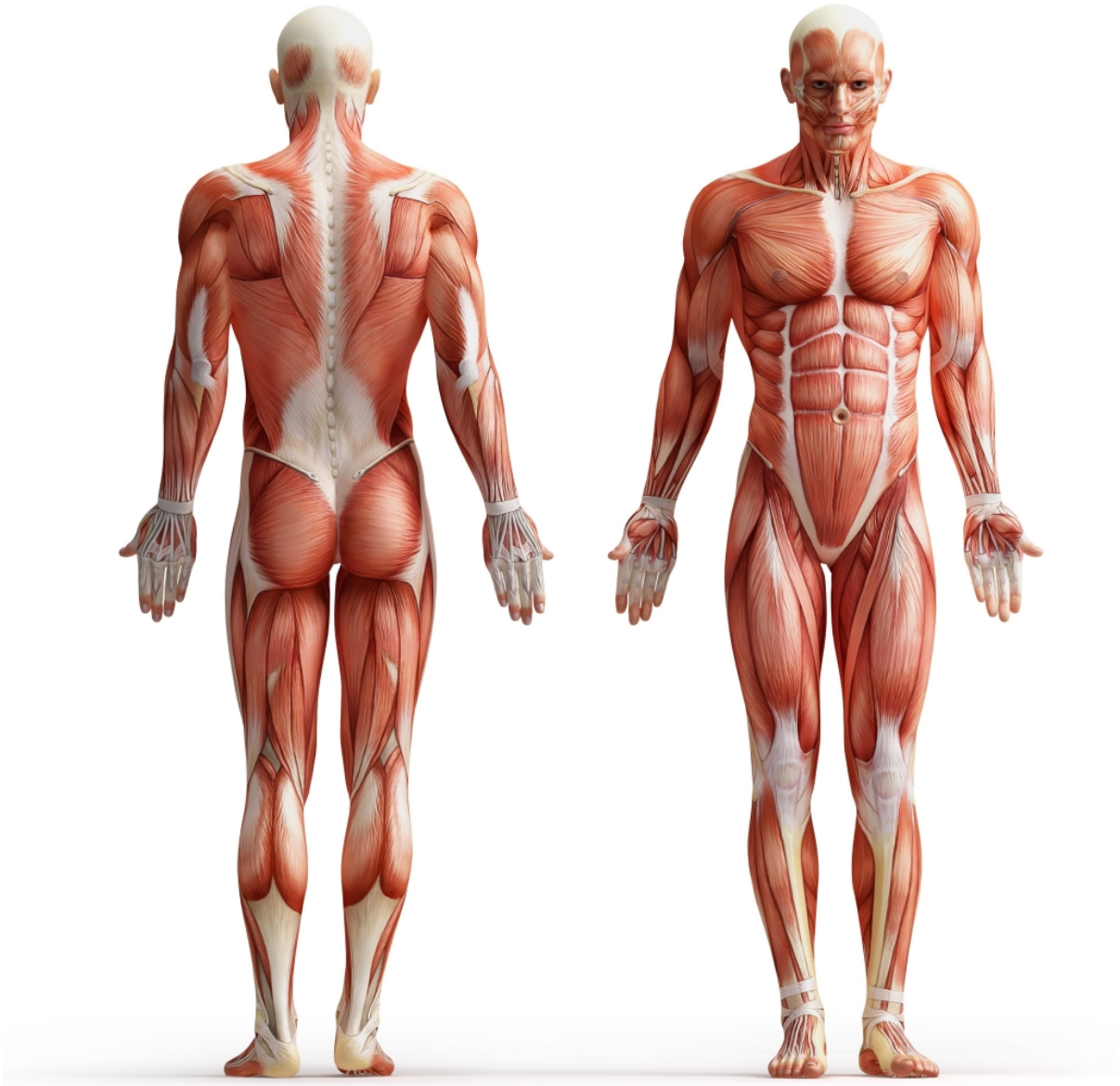
PAIN CHART:

Please CIRCLE & NUMBER areas & levels of pain (10-Most painful 1-Least painful).



Hijama and any other Complementary or Alternative Treatments

Have you had Hijama Therapy before?

When?

How did you react?

Have you had any other physical treatments such as massage, physiotherapy, chiropractic, osteopathic, reflexology, Ruqyah etc?

MENTAL, NEUROLOGICAL AND METAPHYSICAL HEALTH

Do you have any mental health or psychological issues?

Do you have any behavioural issues?

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Are you aware of any metaphysical issues such as Jinn, Black Magic, Evil eye?
Do you follow a religion?
Which one?
Do you pray/meditate?

Current family unit:
Married
Married (Polygynus)
Single/Never married
Single/Divorced
Single/Widowed
Single/Separated
Number of Children?
Biological
Miscarriages
Deceased after birth
Stillborn
Fostered
Adopted
Step-children

Who lives in your household?

Current stress levels? Please describe in detail and mark from 1-10. (10 is most stressful).
Emotional

Mental

Physical

Are you a Student?
F/T or P/T?
Education and qualifications?

Are you employed?
F/T OR P/T?
Job and Title:
Describe your workspace/environment

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DIET & NUTRITION

Describe your daily diet/food intake:

How often do you eat in a day?
What do you eat daily?
Breakfast?
Lunch?
Dinner?
Snacks?
Do you eat a balanced diet?
Are you aware of different food groups; starch, carbohydrates, proteins,
Do you have any food allergies or do you react to certain food groups?
Which oils do you use for cooking?
Which salt do you use for cooking?
Do you suffer from:
Heartburn
Acid reflux
Indigestion
Excessive burping
Flatulence
Wind
Have you had stomach or intestinal surgery such as a Gastric Band?

WATER INTAKE

How much water do you drink daily?
Do you drink:
Tap water
Bottled mineral water
Still water
Sparkling water
Filtered water
Ionized water
Alkaline water
Distilled water
Zam Zam water
Other

OTHER FLUIDS

Tea or Herbal tea
Coffee
Boxed Fruit juices
Diluted squash drink

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Pure, fresh fruit juice
Smoothies
Milk
Soda
Alcohol

URINATION

How often do you urinate daily?
Usual colour of urine
Any burning or discomfort?
Describe your urination problems:

BOWEL MOVEMENTS

How often do you have bowel movement daily?
Do you have to strain or experience pain or bleeding?
Describe your stool-hard, soft, runny?
Do you suffer from constipation? How often?
Do you suffer from Diarrhea? How often?
Do you suffer from Hemorrhoids?

EYESIGHT

Is your eyesight:
Normal
Near-sighted
Far-sighted
Do you wear glasses?
Contact lenses?
Any other eye conditions?

HEAD CONDITIONS

Migraines?	How often?	Which Kind?
Headaches?	How often?	Location?

HAIR

Do you suffer from hair loss and where?
Do you suffer from excessive hair growth and where?
Do you have any hormonal issues?
Do you have any autoimmune conditions?
Are you undergoing any hair related surgery, laser treatment or any other procedures.

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SLEEP

Bed time?
Describe your sleeping patterns/habits?
What time do you usually eat your last meal before sleeping?
What time do you usually wake up?
Quality of sleep-deep and restful?
Restless, Agitated, erratic, disturbed?
Do you sleep walk?
Do you sleep talk?
Do you clench your teeth?
Do you grind your teeth?
Do you wet the bed?
Do you watch TV, use a phone, ipad, tablet, computer or any other electronic devices before sleep?

STRUCTURAL OR MUSCULAR ISSUES

Describe posture-poor, good, excellent.
Do you have any spinal, neck, knee or ankle issues?
Do you suffer from any swelling, inflammation or water retention anywhere?
Do you carry heavy bags or weights in your shoulders or back?
Do you carry children on your hips, on one side?
Are you flatfooted?
Do you have a collapsed arch in either or both feet?
Do you use computers a lot?
Do you suffer from Repetitive Work Syndrome/carpal tunnel?
Do you exercise? Type? How often?
Do you stretch?
Do you suffer from Sciatica?

EXERCISE

How much exercise do you do?
What kinds of exercise do you do?

ENVIRONMENT

Are you aware of any damp or mould in your home?
Are you exposed to a lot of dust, pollen, cold or wet weather?
How much air or dust pollution are you exposed to?
Do you use a dishwasher?
What type of clothes washing detergent do you use?
Do you use soaps, shampoos and other cosmetic chemicals?

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CONTRAINDICATIONS:

Various stages of Pregnancy

IVF Treatment

PRECAUTIONS:

- Diabetes
- Epilepsy, fits or seizures and/or metaphysical issues
- Cuts/abrasions
- Skin Diseases/ disorders
- High/Low Blood Pressure
- Thrombosis/Embolism
- Early and late stages of pregnancy
- Contagious diseases
- Blood Borne Pathogens
- Post-operation of an organ transplant
- Recent Injuries/surgery
- Bleeding disorders & being on blood thinners

- The CHP has fully explained the Hijama procedure, contraindications, outcomes, after effects and post care instructions of the HCT procedure to me, shown me the equipment and I understand the process of HCT.

- I understand it is my responsibility to inform my CHP of any changes in my medical condition or medications and agree to do so at the start of any Hijama sessions.

- I give permission to the CHP to safely and professionally perform Dry and Hijama Wet Cupping on my body, create several, small, shallow incisions by breaking the skin barrier with a size 15, single use, sterile blade or with a diabetic needle and lancet within the circle of the Hijama site. Also, to clean me up, sanitize and seal me with oil.

- I understand that the CHP cannot be held responsible or liable for any contraindications, negative after effects, side effects, injuries, accidents or other liabilities after the HCT treatment.

CHP Name: CHP Signature: Date:

Client Name: Client Signature: Date:

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MALE MEDICAL HISTORY FORM

Do you use any other beauty and cosmetic chemicals/lotions etc?
How much? How often?
Do you use deodorant?
Do you use perfume or after-shave?
Do you use skin bleach?
Do you use hair bleach or hair dye?

REPRODUCTIVE AND SEXUAL HEALTH

Do you have any known spinal issues?
Have you had any recent injuries to your spine or reproductive organs?
Have you had any recent surgeries on your spine reproductive organs?
Do you exercise?
Do you take steroids?
Do you take testosterone supplements?
Do you take any other supplements?
Do you have any of the following issues?

Sperm production problems

- Chromosomal or genetic causes
- Undescended testes (failure of the testes to descend at birth)
- Infections
- Torsion (twisting of the testis in scrotum)
- Varicocele (varicose veins of the testes)

Blockage of sperm transport & Sexual Problems

- Infections
- Prostate-related problems
- Absence of vas deferens
- Vasectomy
- Retrograde and premature ejaculation
- Failure of ejaculation
- Erectile dysfunction
- Infrequent intercourse
- Spinal cord injury
- Prostate surgery
- Damage to nerves

Hormonal problems

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• Pituitary tumours
• Congenital lack of LH/FSH (pituitary problem from birth)
• Anabolic (androgenic) steroid abuse

Sperm antibodies

• Vasectomy
• Injury or infection in the epididymis

(OPTIONAL) FERTILITY

Are you using contraceptives? Which kind?
Are you in a Polygynous marriage?
How often do you engage in (halal) sexual intercourse with your spouse?
Are you fertile now?
Have you been fertile in the past?
If no, have you and/or your spouse had the relevant fertility tests?
What were the results?
Are you undergoing any medical or fertility treatment with your spouse?
Are you undergoing IVF treatment with your spouse? If yes:
For how long?
Which stage of the cycle are you at?
How many cycles have you undergone?

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FEMALE MEDICAL HISTORY FORM

Are you pregnant now? How many weeks?
Are you on your period today?

Do you wear make up? How Much? How often?
Do you use nail polish or wear fake nails?
Do you use any other beauty and cosmetic chemicals/lotions etc?
How much? How often?
Do you use skin bleach?
Do you use hair bleach or hair dye?

REPRODUCTIVE & SEXUAL HEALTH

Describe your Menstrual cycle
When was your last period?
Do you have any other issues with your uterus, fallopian tubes or ovaries?
Have you had a hysterectomy or any other major surgeries on your reproductive or sexual organs?
Do you have any hormonal issues?
Are you pre-menopausal, menopausal or post-menopausal?
Are you undergoing Hormone Replacement Therapy (HRT)?
Number of previous pregnancies?
Live births?
Miscarriages?
Abortions?
Stillborn births?
Deceased after birth?
C-Sections?
Describe previous labour and deliveries:
Are you currently nursing?
When was the last time you had a bra fitting?
Do you know if you are wearing the correct size?
Do you use deodorant?

(OPTIONAL) FERTILITY

Are you taking contraceptives? Which kind?
Are you in a Polygynous marriage?
How often do you engage in (halal) sexual intercourse with your spouse?
Are you fertile now?
Have you been fertile in the past?
If no, have you and/or your spouse had the relevant fertility tests?

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What were the results?
Do you know your ovulation cycle?
How often do you engage in (halal) sexual intercourse with your spouse?
Are you undergoing any medical or fertility treatment?
Are you undergoing IVF treatment? If yes:
For how long?
Which stage of the cycle are you at?
How many cycles have you undergone?

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