Johann Sutherland
T/Dr. Sutherland J (00010809/001)
Cell: +27 81 589 9078
Email: johann@abisinc.org

Mirishin Schutte
T/Dr. Shutte M (00010768/001)
Cell: +27 67 135 3248
Email: mirishin@abisinc.org

Website: www.abisinc.org

ABIS INC.

In association with The Abis Foundation; The Association of Compassion; and
The African Natural Medicine Association.

HEALTH & WELLNESS PATIENT HISTORY FORM

PERSONAL INFORMATION

LAST NAME		POSTAL ADDRESS	
FIRST NAME(S)			
DATE OF BIRTH			
AGE		POSTAL CODE	
GENDER		PHYSICAL ADDRESS	
TEL NO.			
CELL NO.			
EMAIL ADDRESS		POSTAL CODE	
OCCUPATION		MARITAL STATUS	

EMERGENCY CONTACT

CONTACT PERSON	
TEL/CELL NO.	
STREET ADDRESS	

SECTION ONE

Describe in detail the problem(s) for which you seek therapy.
Please include dates when each problem occurred:

Have you ever had this problem(s) before?
Please include dates when each problem occurred:

Please describe your past medical history.
Include approximate dates:

ALLERGIES	
INJURIES	
SURGICAL PROCEDURES	

List any medical tests you have had within the past year:

List any medications or dietary supplements you are currently taking, including over-the-counter:

Are there any daily activities that you are finding difficulty with, or limited too due to the above complaints:

Please list any other Healthcare professionals you are consulting for this problem(s):

Do you exercise? If yes, what kind and how often:

How many hours do you generally sleep at night? Is it restful, if not please give details:

What are your eating habits/diet? (eg. Carnivore; Vegetarian; Vegan; Alkaline etc.)

SECTION TWO

Please indicate from 1 - 4 the frequency of each particular condition:
(Leave blank if the condition is not a problem)

1 **Rarely** (Once a month or less)
2 **Occasionally** (Less than once a week)
3 **Frequently** (More than once a week)
4 **Constantly** (Everyday)

DIGESTION

- ◯ Poor digestion
- ◯ Acid reflux
- ◯ Constipation
- ◯ Diarrhea/loose stool
- ◯ Parasites
- ◯ Nausea/vomiting
- ◯ Heartburn
- ◯ Gas/belching
- ◯ Stomach/intestinal
- ◯ Haital hernia
- ◯ Poor appetite
- ◯ Excessive appetite
- ◯ Hemorrhoids
- ◯ Irritable bowels
- ◯ Blood in stool
- ◯ Stomach ulcers
- ◯ Black/dark stool
- ◯ Light stool
- ◯ Difficulty digesting oily foods

YES	NO	High cholesterol
YES	NO	Gall stones
		Other

RESPIRATORY

- ◯ Dry cough
- ◯ Wet cough
- ◯ Chest tightness
- ◯ Shortness of breath
- ◯ Congestion
- ◯ Allergies
- ◯ Sinus problems
- ◯ Poor sense of smell
- ◯ Nasal problems
- ◯ Wheezing
- ◯ Hay fever
- ◯ Catch colds easily
- ◯ Pneumonia
- ◯ Asthma
- ◯ Bronchitis
- ◯ Emphysema

		Other
YES	NO	Do you smoke?
		Amount per day
		Other

CARDIOVASCULAR

- ◯ Chest pain
- ◯ Dizziness
- ◯ Hypertension
- ◯ Hypo-tension
- ◯ Bruises easily
- ◯ Cold hands/feet
- ◯ Edema
- ◯ Restlessness
- ◯ Heart palpitations
- ◯ Slow heart rate
- ◯ Poor circulation
- ◯ Blood clots
- ◯ Poor blood clotting
- ◯ Anemia
- ◯ Sweaty hands/feet
- ◯ Pacemaker

HIGH	LOW	Blood pressure
YES	NO	Heart disease
YES	NO	Phlebitis
YES	NO	Heart attack
		How many?
YES	NO	Stroke
		How many?
		Other

URINARY

- ◯ Painful urination
- ◯ Incontinence
- ◯ Ringing in ears
- ◯ Ear aches

YES	NO	Difficulty urinating
YES	NO	Kidney stones

YES	NO	Kidney infections
YES	NO	Lower back pain
YES	NO	Knee problems
		Other

MUSCLES / JOINTS

Indicate YES or NO for painful area and tick left/right side.

YES	NO	Hands	L	R
YES	NO	Arm	L	R
YES	NO	Shoulder	L	R
YES	NO	Elbow	L	R
YES	NO	Hip	L	R
YES	NO	Legs	L	R

YES	NO	Knee	L	R
YES	NO	Foot	L	R
YES	NO	Neck	L	R
YES	NO	Upper back	L	R
YES	NO	Middle back	L	R
YES	NO	Lower back	L	R

YES	NO	Limited movement

Where?

YES	NO	Previous bone fractures
YES	NO	Bone spurs
YES	NO	Disk degeneration
YES	NO	Osteoporosis
YES	NO	Arthritis

NERVOUS SYSTEM

YES NO Numbness

Where?

YES NO Tingling

Where?

YES NO Nervous disorder

Type

YES NO Multiple Sclerosis

YES NO Muscular dystrophy

YES NO Epilepsy

YES NO Dyslexia

YES NO Learning disorder

YES NO Head injury

YES NO Developmental/growth issues

FEMALE BORN ONLY

YES NO Breast pain/tenderness

YES NO Breast lumps

YES NO Nipple discharge

YES NO Menopause

YES NO PMS

YES NO Infertility

YES NO Ovarian cysts

YES NO Endometriosis

YES NO Painful menstrual cycles

YES NO Heavy/exessive flow

YES NO Painful intercourse

YES NO Currently pregnant

Number of pregnancies

Number of children

Age(s) of children

Nature of birth(s)

Any birth complications

MALE BORN ONLY

◯ Problems urinating

◯ Prostate problems

◯ Pain associated with genitals

◯ Impotence

YES NO Prostate cancer

YES NO Infertility

OTHER

◯ Insomnia

◯ Depression

◯ Anxiety

◯ Oversleeping

◯ Shaky

◯ Poor memory

◯ Lack of concentration

◯ Easily angered

◯ Obsessive tendencies at work

YES NO Prescription glasses

YES NO Poor hearing

YES NO Dental problems

YES NO Difficulty swallowing

YES NO Weight gain

YES NO Weight loss

YES NO Diabetes

YES NO Tuberculosis

YES NO Thyroid problems

YES NO Fibromyalgia

YES NO Recent steroid injections

YES NO Medical/artificial implants

◯ Difficulty making decisions

◯ Dizziness

◯ Brittle nails

◯ Intolerance to temperature changes

◯ Fatigue

◯ Difficulty with speech

◯ No thirst

◯ Excessive thirst

◯ Sleep apnea

YES NO Poor sense of taste

YES NO Poor sense of smell

YES NO Herpes

YES NO Candida

YES NO Infectious disease

YES NO Shingles

YES NO Cancer

YES NO Hepatitis

YES NO HIV/AIDS

YES NO Allergies

YES NO Skin conditions

YES NO Chemical dependency

◯ Dry mouth

◯ Pain at night

◯ Headaches

◯ Migraines

◯ Eye pain

◯ Dry eyes

◯ Double vision

◯ Jaw-clenching (Bruxism/TMJ)

Other eye problems

Nature of your own birth

Any birth complications

Auto-immune/inherited conditions

Please indicate from 1 - 3 the frequency of each particular condition:
(Leave blank if the condition is not a problem)

1 Never 2 Rarely 3 Daily

- ◯ Tobacco ____ Amount per day
- ◯ Alcohol ____ Amount per day
- ◯ Caffeine ____ Amount per day
- ◯ Carbonated Soda ____ Amount per day
- ◯ Recreational drugs ____ Amount per day

What drugs?

Do you experience any of these emotions on a regular basis?

◯ Abused	◯ Despair	◯ Guilty	◯ Apprehensive	◯ Restless
◯ Criticized	◯ Helpless	◯ Paranoid	◯ Uneasy	◯ Agitated
◯ Over-worked	◯ Hopeless	◯ Anxious	◯ Distressed	◯ Panic
◯ Paralyzed	◯ Easily irritated	◯ Sad	◯ Fearful	◯ Intolerant
◯ Depressed	◯ Overwhelmed	◯ Grieving	◯ Impatient	◯ Uncertain
◯ Rejected	◯ Persecuted	◯ Unable to grieve	◯ Intimidated	◯ Aggravated
◯ Annoyed	◯ Angry	◯ Outraged	◯ Nervous	◯ Worried

Please indicate from 1 (low) - 10 (high) the levels of stress you are currently experiencing:

◯ Family stress ◯ Relationship stress ◯ Work stress ◯ Financial stress ◯ Health stress

Other

How much time do you give yourself to relax? What do you do? - hobbies; meditation etc:

Please rate your happiness levels from 1 (low) - 10 (high)

◯ Personal happiness ◯ Career happiness

Do you have WIFI at home? How often is it on/off?:

What are your spiritual/religious beliefs? Do you follow a particular tradition or culture?:

Are you willing to let go? And work on mind, body, as well as soul:

PATIENT COMMENTS

PRACTITIONER COMMENTS

INDEMNITY AND CONFIDENTIALITY AGREEMENT

I, of on this day

accept that Mirishin of Abis Incorporated may discuss, recommend and/or prescribe complementary modes of care for myself/my child/or my pet, including referrals to general practitioners, boarded specialists, other alternative medical caregivers, conventional medical or surgical care, or a combination of these options. I understand that information exchanged with the Abis Incorporated practitioner is confidential and will not be released without my prior written consent. I understand that by providing this informed consent, I am assuming full responsibility for my Abis I ncorporated treatment.

General Agreement

I hereby consent to the necessary investigations and treatments that the above listed practitioner may find appropriate. I understand that the t reatment may include the use of herbs in their various applications as used by Herbal Practitioners (Herbalists), nutraceuticals, nutritional advice, and various natural therapies. I confirm that I have disclosed all information relative to my medical history and current condition. I understand that this agreement is relative to the attached documents of disclosure, pertaining to my medical history, medication currently on, and current condition. I understand that if I am under treatment of a medical practitioner, that I will confirm and discuss the use of, or complementary use of any suggestions by the practitioner, including natural remedies, treatments given / suggested in respect of his/her treatment and referrals to other medical practitioners. I understand that payment is due at the time of service. Since time has been especially reserved for me, I understand a 24-hour cancellation notice is expected, and missed appointments will be charged for in full. It is my understanding that I will be provided information from Mirishin of Abis Incorporated, related to all health products, and to any additional diagnostic tests and/or treatment using this type of medical and follow-up care.

Client Signature **Date**