



Health Information

PERSONAL INFORMATION

Name _____
Phone

Social Security Number _____
Date of Birth

Address

City/State/Zip

In case of serious accident or illness notify:

Name _____
Phone

Address

City/State/Zip

PERSONAL HISTORY

Have you ever had?	Yes	No		Yes	No
Scarlet Fever	_____	_____	Frequent Anxiety	_____	_____
Measles	_____	_____	Frequent Depression	_____	_____
Rubella (German measles)	_____	_____	Worry or Nervousness	_____	_____
Mumps	_____	_____	Mental Illness	_____	_____
Chicken Pox	_____	_____	Recurrent Colds	_____	_____
Diabetes	_____	_____	Head Injury with		
Malaria	_____	_____	Unconsciousness	_____	_____
AIDS or HIV positive	_____	_____	Epilepsy/Convulsions	_____	_____
Tuberculosis	_____	_____	Hay Fever/Asthma	_____	_____
Migraine Headaches	_____	_____	Shortness of Breath	_____	_____
Venereal Disease	_____	_____	High/Low Blood Pressure	_____	_____
Albumen/Sugar in Urine	_____	_____	Rheumatic Fever	_____	_____
Frequent Urination	_____	_____	Heart Murmur	_____	_____
Infectious Hepatitis	_____	_____	Tumor, Cancer Cyst		
Cancer	_____	_____	Dizziness/Fainting	_____	_____
Pain/Pressure in Chest	_____	_____	Weakness/Paralysis	_____	_____
Chronic Cough	_____	_____	Palpitations (Heart)	_____	_____
Heart Disease	_____	_____	Currently Pregnant	_____	_____
Menstrual Difficulties	_____	_____	Insomnia	_____	_____

1. How would you describe your general health? _____ Good _____ Fair _____ Poor

If not good, explain. _____

2. List any physical or emotional problems about which the Foundation Healing School might need to know in providing for your personal or medical needs.

3. Has your physical activity been restricted during the past five years? (Give reasons and durations.) _____

4. Have you received treatment or counseling for a nervous condition, personality disorder or emotional problem? If so, please explain. _____

5. Have you had any illness or injury or been hospitalized other than already noted? (give details.) _____

6. Do you need or take any medicine by prescription? (Please list.) _____

7. Are you allergic to any drug, medication, serum, etc.? (Please explain.) _____

8. Personal physician: Name _____ Address _____

Phone _____ Date of last exam (must be within last 12months) _____

9. Dates of sessions with licensed mental health professional (must be within 12 months immediately prior to apprenticeship, 1/2 may be done during first six months of apprenticeship)

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

9. _____ 10. _____

I, the undersigned, have been fully informed by Debby Singleton that participants in the apprenticeship program already in the process of releasing emotional and chemical toxins may find energy balancing accelerates that process.

I hereby consent to such participation and agree to hold Debby Singleton, Arasini Foundation and its students free and harmless for any claims, demands, or suits for damages from any injury or complications, which may result from such participation in the apprenticeship program.

Signature

Witness

Date