



HEALTH HISTORY

Name: _____ DOB: _____ Date: _____

Occupation: _____ Weight: _____ Height: _____ Gender: _____ Number of Children: _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Referred by: _____

List of current health problems for which you are being treated: _____

Reason for initial visit: _____

Name of GP/Specialists: _____

What types of therapies have you tried for these problem(s) or to improve your health overall:

- diet modification vitamins/minerals herbs homeopathy chiropractic massage acupuncture OTC/prescription drugs other _____

Do you experience any of these general symptoms on a regular basis?

- allergies depression food cravings intolerance to extreme temperatures skin issues
 bruising diarrhea gas/bloating irritated bowel urinary incontinence
 chronic pain/inflammation disinterest in sex hair loss nausea vomiting
 constipation dizziness headaches panic attacks water retention
 cough fatigue insomnia shortness of breath

Current prescription or over-the-counter medications: (Please bring them with you to your appointment): _____

Please bring any lab work from within the last 12 months including blood, urine, saliva, and hair analysis.

Major hospitalizations, surgeries, injuries: (Please list all procedures, complications (if any) and dates):

Table with 3 columns: Year, Surgery, Illness, Injury, Outcome

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., family, changes in job/work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today: _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. fireman, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/Hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia

- Prostate cancer
- Decreased sex drive
- Erectile Dysfunction
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-Section
- Age of first period _____
- Date-last menstrual cycle _____
- Length of cycle (days) _____
- Interval of time between cycles (days) _____
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, light) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: #day _____
- Cigars: #day _____
- Alcohol:
- Wine: #glasses day/wk _____
- Liquor: #ounces day/wk _____
- Beer: #bottles day/wk _____
- Caffeine:
- Coffee: #6 oz cups/day _____
- Tea: #6 oz cups/day _____
- Soda w/caffeine: #cans/day _____
- Other sources _____
- Water: #glasses/day _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk _____
- Run, jog, other aerobic - #days/wk _____
- Weight lift - #days/wk _____
- Stretch (Yoga) - #days/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- Total calorie restriction
- Specific food restrictions:
- dairy gluten eggs
- soy corn nuts
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc) _____
- Dark green or deep yellow/orange vegetables _____
- Grains _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____
- Desserts/Sweets _____

Eating Habits

- Skip meals – which ones _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)

- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin D
- Vitamin E
- EFA/Fish Oil
- Calcium
- Magnesium
- Iron
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Other _____

I would like to:

- Energy-Vitality
- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get fewer colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications
- Stop using laxatives and stool softeners
- Improve sex drive
- Body Composition
- Lose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible
- Stress, Mental, Emotional
- Learn how to handle stress
- Think more clearly and be more-focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated
- Life Enrichment
- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

Signed Disclaimer