HEALTH HISTORY

NAME: _____DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____WORK PHONE: _____CELL PHONE:_____

EMAIL:_____

DATE OF BIRTH: _____WEIGHT: _____ HEIGHT:_____

Reason for consultation and/or goals: _____

_____

_____

Do you smoke?_____ Drink alcohol? _____ How much/when?_____

Do you drink caffeine every morning?_____

Do you have food allergies, restrictions, or sensitivities? _____

_____

Describe your daily energy levels: _____

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? _____

Do you crave certain foods? _____ If so, which foods and when?_____

_____

Do you crave any of the following?

❒ Sugar ❒ Meat Fat ❒ Chocolate ❒ Fish ❒ Alcohol

❒ Desserts ❒ Milk ❒ Bread ❒ Fried foods ❒ Other _____

Do you take any nutritional supplements or vitamins? _____ If so, which ones? (be specific. Attach sheets if necessary)

_____

_____

Which prescription and over the counter medications do you take regularly? _____

_____

_____

Which oils do you use/consume?

❒ Butter ❒ Peanut Oil ❒ Canola ❒ Margarine ❒ Corn Oil ❒ Sun/Safflower ❒ Olive Oil

❒ Crisco ❒ Mayonnaise ❒ Coconut Oil ❒ Vegetable Oil ❒ Flaxseed Oil ❒ Soybean Oil ❒ Other_____

How is your dental health? _____

How many bowel movements do you have a day? _____

Rank your skin without lotion: ❒ Very Dry ❒ Dry ❒ Normal ❒ Oily ❒ Combination

Please check off any of the following that pertain to you (past or present – please mark present conditions with a P next to it):

❒ Acne
❒ Addiction (alcohol, drugs)
❒ Anemia
❒ Anorexia
❒ Anxiety or nervousness
❒ Arthritis (Rheumatoid or Osteo)
❒ Bladder infections (Cystitis)
❒ Bloating, gas or indigestion
❒ Blood Sugar problems
❒ Bronchitis
❒ Cancer
❒ Colds or flu (frequent)
❒ Cold Sores
❒ Chronic fatigue
❒ Constipation
❒ Dandruff
❒ Depression
❒ Diabetes I (insulin dependent)
❒ Diabetes II (adult onset)
❒ Diarrhea
❒ Difficulty loosing weight
❒ Difficulty gaining weight
❒ Emotional problems (instability or sensitivity)
❒ Emphysema
❒ Fainting
❒ Gall bladder problems
❒ Gout
❒ Hair loss or poor hair growth
❒ Headaches
❒ Heart disease or problems
❒ Heartburn
❒ Hemorrhoids
❒ Herpes simplex or type II
❒ High blood pressure
❒ High cholesterol
❒ HIV
❒ Hot flashes
❒ Hypoglycemia
❒ Insomnia
❒ Intestinal problems
❒ Kidney stones
❒ Liver problems
❒ Loose stools
❒ Memory loss or confusion
❒ Nails, poor growth
❒ Panic attacks
❒ Parasites
❒ Pregnant or nursing mother
❒ Respiratory problems
❒ Ringing in ears
❒ Seizures
❒ Severe mood swings
❒ Skin conditions
❒ Stroke
❒ Suicidal tendencies
❒ Thyroid condition
❒ Ulcer
❒ Yeast infections

Women: Please check all that pertain:
❒ PMS
❒ Irregular periods
❒ Painful periods
❒ Loss of periods
❒ Birth control pills
❒ Menopause
❒ Painful intercourse
❒ Children
❒ Hysterectomy

Men: Please check all that pertain:
❒ Frequent urination
❒ Difficulty urinating
❒ Difficulty with erection
❒ Loss of libido
❒ Prostate enlargement

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____

_____

_____

_____

Personal weight loss history: How many diets have you been on? _____ Which ones? _____

What were your results? _____

Do you exercise? _____ If so, what kind? _____

How often: Since when? _____

Please rate the following:

Daily energy level: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Energy level after exercise: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Daily stress level: ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ None

Do you have a support system of family and friends? _____

General enjoyment of life: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

How many hours do you sleep? _____ Do you sleep throughout the night?_____ Do you wake up without an alarm? _____

Do you wake up feeling rested? _____ Do you fall asleep within 15 minutes?____

Please describe any health concerns you think are important: _____

_____

_____

_____

By signing below, you acknowledge that any dietary or supplemental suggestions made by _____, are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

Signed: _____ Date: _____