

Health History
Please write or print clearly

Date: _____

Name: _____ Address: _____

Email: _____ Telephone – work: _____

Home: _____ Cell: _____ Age: _____ Height: _____

Date of birth: _____ Place of birth: _____

Relationship status: _____ Children? _____

Occupation: _____ Hours of work per week: _____

How much stress do you feel you are experiencing in your life right now?

Minimal Average Considerable Unbearable

What are the major causes of your stress? (check all that apply)

Financial Career Personal Marriage Health

Family Spiritual Unfulfilled expectations

Other (please elaborate) _____

Do you sleep well? _____ Do you wake up at night? _____ What times? _____

To urinate? _____ What time do you generally get up in the morning? _____

Constipation/Diarrhea? _____ Explain: _____

What blood type are you? _____ What is your ancestry? _____

Women: Are your periods regular? _____ How many days is your flow? _____

How frequent? _____ Painful or symptomatic? _____

Please explain: _____

Current weight: _____ Weight 6 months ago: _____ 1 year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Do you take any supplements or medications? If so, which? _____

Are there any healers, helpers or therapies with which you are involved?

Please list: _____

What role does exercise play in your life? _____

How many hours a day do you:

___ watch TV? ___ read? ___ spend in front of a computer?

What are your interests and hobbies? _____

Do you drink coffee, smoke cigarettes or have any major addictions? _____

What percentage of your food is home cooked? ___ Where do you get the rest from?

Serious illness / hospitalizations / injuries? _____

What is your chief concern? _____

Other concerns? _____

How is the health of your mother?

How is the health of your father?

Do you eat or use:

___ fried foods ___ refined food ___ candy

___ microwave ___ luncheon meats ___ cigarettes

___ aluminum pans ___ margarine ___ fast foods

___ Splenda ___ Nutra-Sweet/Aspartame

What are your favorite foods?

How often do you eat them?

Do you experience symptoms if meals are missed?

Explain: _____

Do you avoid certain foods? If so, why?

Do you experience any symptoms after meals? Explain:

Health History – Part Two
Please write or print clearly

What foods did you eat often as a child?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
.....
.....
.....
.....
.....

What about one year ago?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
.....
.....
.....
.....
.....

What's your food like these days?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
.....
.....
.....
.....
.....