

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?

- | | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Meat Fat | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fish | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Desserts | <input type="checkbox"/> Milk | <input type="checkbox"/> Bread | <input type="checkbox"/> Fried foods | <input type="checkbox"/> 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?

- | | | | | | | |
|---------------------------------|-------------------------------------|--------------------------------------|--|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola | <input type="checkbox"/> Margarine | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower | <input type="checkbox"/> Olive Oil |
| <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise | <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Soybean Oil | <input type="checkbox"/> 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):

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Difficulty losing weight | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Addiction (alcohol, drugs) | <input type="checkbox"/> Difficulty gaining weight | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional problems (instability or sensitivity) | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Memory loss or confusion |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nails, poor growth |
| <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Bladder infections (Cystitis) | <input type="checkbox"/> Gout | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Bloating, gas or indigestion | <input type="checkbox"/> Hair loss or poor hair growth | <input type="checkbox"/> Pregnant or nursing mother |
| <input type="checkbox"/> Blood Sugar problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart disease or problems | <input type="checkbox"/> Ringing in ears |

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colds or flu (frequent) | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Severe mood swings |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Herpes simplex or type II | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Suicidal tendencies |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes I (insulin dependent) | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Diabetes II (adult onset) | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal problems | |

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: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | |
| Energy level after exercise: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | |
| Daily stress level: | <input type="checkbox"/> Very High | <input type="checkbox"/> High | <input type="checkbox"/> Moderate | <input type="checkbox"/> Low | <input type="checkbox"/> 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: _____