

# 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 _____ |

Do you eat primarily organic fruits, vegetables and dairy products? \_\_\_\_\_

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"/> Multiple chemical sensitivity |
| <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? \_\_\_\_\_

How is your dental health? \_\_\_\_\_

Have you had silver dental fillings? \_\_\_\_\_ How many? \_\_\_\_\_ Have they been removed? \_\_\_\_\_

Do you use environmentally friendly household products? \_\_\_\_\_

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: \_\_\_\_\_