

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ # of Children _____

Marital Status Single Partner Married Separated Divorced Widow(er)

Reason for office visit: _____

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

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

Diet modification Fasting Vitamins/minerals Herbs Homeopathy Chiropractic Acupuncture Conventional drugs

Do you experience any of these general symptoms EVERY DAY?

Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation

Depression Panic attacks Nausea Fecal incontinence Bleeding

Disinterest in sex Headaches Vomiting Urinary incontinence Discharge

Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash

Current medications (prescription or over-the counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): _____

Outcome _____

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

Year	Surgery, illness, injury	Outcome
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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Circle the level of stress you are experiencing on a scale of 1 to 10 (1 is the lowest) 1 2 3 4 5 6 7 8 9 10

Identify major causes of stress (e.g., changes in job, work, residence, 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 (i.e., 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, elevate
- 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
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

MEDICAL (MEN)

- Benign prostatic hyperplasia
- Prostrate cancer

- Decreased sex drive
- Infertility
- 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 _____
- Mammogram + -
- Pap + -
- 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, scanty) _____

- Surgical menopause
- Menopause

FAMILY HEALTH HISTORY

- (Parents & 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 d or wk _____
- Liquor: #/glasses d or wk _____
- Beer: #/glasses d or wk _____
- Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

EXERCISE

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

NUTRITION & DIET

- Mixed food diet (animal & vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- dairy wheat eggs
- soy corn all gluten
- Other _____

FOOD FREQUENCY

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

EATING HABITS

- Skip meals (which ones) _____
- _____
- One meal a day
- Two meals a day
- Three meals a day
- Graze (small, frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

CURRENT SUPPLEMENTS

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Others _____

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 less colds and flu
- Get rid of allergies
- Not be dependent on over-the-Counter medications like aspirin, ibuprofen, anti-histamines, sleep aids, etc.
- 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 reduce 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 risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from "treating illness" to a wellness lifestyle