

Name:

date:

Address:

Telephone

best time to call:

Date of birth:

Weight:

Height:

Occupation:

Current health practitioner(s) you work with:

Current prescription medications:

Current over-the-counter medications and supplements:

Allergies, Food Intolerances, etc:

Please describe your most important health concern(s):

Dietary Summary

outline a typical day:

Breakfast	Lunch	Dinner	Snacks

Water intake:

Other fluids:

Food cravings:

Food sensitivities/allergies:

Food preferences (circle all that apply)

sweet sour salty bitter spicy

Do you prefer cooked foods or raw/cold foods?

Eating schedule/habits: (include snacks, etc)

Typical eating environment: (at home, at work, sitting, standing, while driving, etc...)

How often do you prepare your own food?

Frequency of consumption (how many servings/week)

- | | |
|----------------------------|-----------------------------|
| ___ coffee/caffeinated tea | ___ soda |
| ___ alcoholic beverages | ___ sweets |
| ___ eating out | ___ fresh fruits/vegetables |
| ___ animal protein | ___ soy products |

Medical and Family History:

for the following, please note if they apply to your mother, father, siblings, and/or self

- | | |
|--------------------------|----------------------------------|
| _____diabetes | _____autoimmune disease |
| _____heart disease | _____tumor(s), cancer |
| _____stroke | _____substance abuse/addiction |
| _____high blood pressure | _____arthritis |
| _____high cholesterol | _____liver disease |
| _____depression | _____kidney disease |
| _____mental illness | _____reproductive/sexual disease |
| _____other | |

Do you have any children?

Age(s):

for the following, please include dates and length of illness and recovery:

Major injuries:

Surgical operations:

Other hospitalization:

Recent illness:

Childhood illness(es):

- | | |
|--------------------------------|------------|
| Do you smoke tobacco? | how much? |
| Do you use smokeless tobacco? | how much? |
| Do you use recreational drugs? | how often? |

Please list any allergies to medications, chemicals, and environmental factors (pollen, dust, etc)

for the following, please check any that apply, and provide additional information as needed:

Digestive Health:

- | | |
|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Nausea (when – how?) |
| <input type="checkbox"/> Gingivitis/Periodontal disease | <input type="checkbox"/> Cavities |
| <input type="checkbox"/> Frequent burping | <input type="checkbox"/> Stomach pain/cramping |
| <input type="checkbox"/> Heartburn (how often?) | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Intestinal pain/cramping | <input type="checkbox"/> Frequent antibiotic use |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Incomplete digestion | <input type="checkbox"/> Blood in stool |

Frequency of bowel movements:

Quality of bowel movements (color/consistency)

Kidney and urinary system health:

- | | |
|---|---|
| <input type="checkbox"/> Dull pain in lower back | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Urinary tract infection(s) |
| <input type="checkbox"/> Yeast infection(s) | <input type="checkbox"/> Water retention |
| <input type="checkbox"/> Bladder control problems | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Decreased urine flow |

Frequency of urination:

Quality of urine (color/odor)

Respiratory system health:

- | | |
|--|---|
| <input type="checkbox"/> Nasal congestion (when?) | <input type="checkbox"/> Sinus infections |
| <input type="checkbox"/> Tenderness around eyes/back of neck | <input type="checkbox"/> Morning stuffiness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Wheezing upon exertion |
| <input type="checkbox"/> Bronchitis (when?) | <input type="checkbox"/> Hoarseness/sore throat |
| <input type="checkbox"/> Pneumonia (when?) | <input type="checkbox"/> Tuberculosis (when?) |
| <input type="checkbox"/> Frequent lung congestion | <input type="checkbox"/> Recurrent cough |

Mucus production in nose and/or lungs? how often?

Color of mucus: Thickness:

Energy reserves and stress:

- | | |
|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Easily tired |
| <input type="checkbox"/> Low energy in morning | <input type="checkbox"/> Low energy in afternoon |
| <input type="checkbox"/> Low energy in evening | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Job stress | <input type="checkbox"/> Family stress |
| <input type="checkbox"/> Debilitating disease | <input type="checkbox"/> Current or past trauma |
| <input type="checkbox"/> Relaxation program | |

Favorite time of the day:

Of year:

Favorite type of weather:

Exercise frequency, type, and duration:

How well do you handle pressure?

When you get sick, where/how do you typically get sick?

Specific stressors right now:

Cardiovascular (heart, blood vessels, and circulation) health:

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> "Hardening of the arteries" | <input type="checkbox"/> Heart palpitation |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart valve dysfunction |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Numbness/tingling in fingers or toes |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Rarely sweat | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Pain/cramping in legs | <input type="checkbox"/> Swelling in hands/feet/ankles |
| <input type="checkbox"/> Chronic wounds/ulcerations on feet/legs | |

Blood pressure:

Resting heart rate (bpm):

Total Cholesterol:

HDL:

LDL:

Immune function:

- Frequent illness
- Fever (temperature)
- Dust allergies
- Pet allergies
- Reactions to vaccines
- Muscle tenderness/soreness
- Recurrent infections

- Wounds heal slowly/prone to infection
- Seasonal allergies
- Mold allergies
- Chemical sensitivity
- Sensitivity to medication
- Joint tenderness/soreness
- Recurrent rashes/skin irritation

Immunization(s) received:

Chronic conditions:

Metabolic function:

- Diabetes/pre-diabetic/insulin resistant
- Light-headed before meals
- Thyroid disease/dysfunction
- Hepatitis
- Jaundice
- Frequently hot
- Overweight
- Abdominal pain

- Hypoglycemia
- "Heaviness" after meals
- Hormonal dysfunction
- Cirrhosis
- Alcohol/drug abuse
- Frequently cold
- Underweight
- Ringing in the ears

Fasting blood glucose level (if known):

Nervous system health:

- Sleep less than 6 hours/night
- Tired upon waking
- Anxiety
- Depression
- Head injury
- "Pinched nerve"
- Mental illness
- Radiating or shooting pain
- Tremors/shaking
- Chronic tension

- Sleep more than 8 hours/night
- Dreams
- Panic attacks
- Spinal injury
- Herniated disks
- Paralysis
- Numbness/tingling
- Sciatic nerve pain
- Poor muscle control
- Headache (how often?)

Headache/pain recurrence: daily weekly monthly seasonal

Aggravating factor(s) for headache/pain recurrence:

Muscle/Bone/Joint health:

- | | |
|--|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Brittle nails |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Poor flexibility |
| <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic swelling/inflammation |

Results of bone density test (if applicable):

Women's reproductive health:

- | | |
|---|--|
| <input type="checkbox"/> Using birth control medication | <input type="checkbox"/> Using hormone replacement therapy |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Uterine cysts |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Premenstrual symptoms |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Breast lump(s)/fibrocystic tissue |
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Overactive libido |
| <input type="checkbox"/> Underactive libido | |

Menstrual cycle (if not menstruating, describe your cycle in the past)
Duration (days): Frequency (days): Regular?

Blood flow (heavy, medium, light):

Clotting blood in menstrual flow? Unpredictable cycle?

History of pregnancy and labor:

Results of last gynecological exam/pap smear:

Men's reproductive health:

- | | |
|---|--|
| <input type="checkbox"/> Erectile dysfunction (impotence) | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Urinary difficulties | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Painful ejaculation |
| <input type="checkbox"/> Prostatitis (BPH) | <input type="checkbox"/> Prostate cancer |
| <input type="checkbox"/> Testicular cancer | <input type="checkbox"/> Reproductive hormone imbalance(s) |
| <input type="checkbox"/> Overactive libido | <input type="checkbox"/> Underactive libido |

Emotional/Spiritual/Community health:

What are the predominant emotions in your life (circle all that apply):

joy	sadness	anger	compassion
jealousy	rage	nostalgia	emptiness
love	grief	worry	regret
inspiration	anticipation	excitement	
other:			

How are your relationships:

With family:

With friends:

With your partner:

With your community:

Do you have a network for support you can call on?

What do you do for fun? What do you do to relax?

I always wanted to be _____

I always wanted to do: _____

Do you have a spiritual practice? How does it make you feel?

Results of lab work and relevant testing: