

Confidential Health History

Please type or write/print clearly

Name:

Address:

Email address:

How often do you check email?

Telephone – Work:

Home:

Cell:

Age:

Height:

Date of Birth:

Place of Birth:

Current weight:

Weight six months ago:

One year ago:

Would you like your weight to be different?

If so, what?

Relationship status:

Children:

Pets:

Occupation:

Hours of work per week:

Please list your main health concerns:

Other concerns and/or goals?

At what point in your life did you feel best?

Any serious illnesses/hospitalizations/injuries?

How is/was the health of your mother?

How is/was the health of your father?

What is your ancestry?

What blood type are you?

Do you sleep well?

How many hours?

Do you wake up at night?

Why?

Any pain, stiffness or swelling?

Note: This Section is for women only

Are your periods regular?

How many days is your flow?

How frequent?

Painful or symptomatic? Please explain:

Reached or approaching menopause?

Please explain:

Birth control history:

Do you experience yeast infections or urinary tract infections?

Please explain:

Constipation/Diarrhea/Gas?

Please explain:

Allergies or sensitivities?

Please explain:

How is your oral health history?

Any root canals? Fillings?

Bleeding gums?

Do you take any supplements or medications?

Please list:

Any healers, helpers or therapies with which you are involved?
Please list:

What role does sports and exercise play
in your life?

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

What's your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

What percentage of your food is home cooked?

Do you cook?

Where do you get the rest from?

Do you crave sugar, coffee, cigarettes, or have any major addictions?

The most important thing I should change about my diet to improve my health is:

Anything else you want to share?