Health History

Please write or print clearly

Date: _____

Are you subscribed to our newsletter? **Would you like to be added?**

Name: _____ **Email:** _____

Address: _____

Telephone – Work: _____ **Home:** _____ **Cell:** _____

Age: _____ **Height:** _____ **Date of Birth:** _____ **Place of Birth:** _____

What blood type are you? _____ **What is your ancestry?** _____

Current weight: _____ **Weight six months ago:** _____ **One year ago:** _____

Would you like your weight to be different? _____ **If so, what?** _____

Relationships status: _____ **Children?** _____

Occupation: _____ **Hours of work per week:** _____

Do you sleep well? _____ **Do you wake up at night?** _____ **What times?** _____

To urinate? _____ **What time do you generally get up in the morning?** _____

Do you generally have good energy? _____

Constipation/Diarrhea/Gas? _____ **Explain:** _____

Check all that generally apply to you.

	Yes	No
Feel cold often?		
Dislike the cold?		
Feel hot often?		
Dislike the heat?		
Daytime sweats?		
Nighttime sweats?		
Sweaty palms or soles of feet?		
Cold hands or feet?		
Small but frequent thirst?		
Big thirst?		

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No thirst?		
Like ice water?		
Breast fed as a baby?		
Frequent urination?		
Dark urine?		
Any Heart concerns?		
Any respiratory concerns?		
Ringing in the ears?		

Antibiotic history: (how often) _____

Long term prescription drug use? _____ **Explain:** _____

Any problems with thyroid? _____

Do you have any pain, stiffness or swelling in the body? _____ **Explain:** _____

Yeast infections, athlete's foot, etc. common? _____

Last Cholesterol reading and date: _____

Serious illness/ hospitalizations/ injuries? _____ **Explain:** _____

Any current or past disease, viruses or infections? _____ **Explain:** _____

Please list past or current disease or disorders that run in your family, with the family member affected:

Please list current supplements and medications:

Vitamin/Food Based: **Prescription:** **Other:**

Are there any healers, helpers or therapies with which you are involved? _____

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What role does exercise play in your life?

Do you follow a regular awareness practice (meditation, affirmation, prayer?

Do you drink coffee? **Smoke?**

Drink alcohol? **Use a microwave?**

Aluminum or Teflon cookware?

Any other addictions past or present (food related or other?): **Explain:**

What % of your food is home cooked? **Where do you get the rest from?**

Please list your chief health concerns that you would like to improve (physical or emotional):

1.

2.

3.

4.

Other concerns?

Women:

Are your periods regular? **How many days is your flow?** **How frequent?**

Painful or symptomatic? **Explain:**

Mark if the symptoms on the left are pronounced or more noticeable pre-menstrual or with your menses.

	Generally	PMS	Menses
Bloating			
Breasts Tender			
Cramping			
Moodiness/Irritable			
Depression			

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Anxiety			
Highly emotional			
Fuzzy thinking/lack focus			
Low back pain			
Neck/ Shoulder pain			
Headaches			
Dizzy			
Water retention			
Mucus issues			
Acne/Skin eruption			
Rash or Itchy skin			
Dry Skin			
Bone problems			

Health History - Part Two

Please write or print clearly

Please list what you current eat for:

Breakfast	**Mid morning snack**	**Lunch**	**Mid afternoon snack**

Dinner	**Desserts**	**Liquids**

Is your diet mostly cooked, raw or a combination? _____

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Please circle if you eat the following. Place an "O" next to the word for often, "S" for sometimes, "N" never

Beef	Cow milk	Pastries/cookies/candy	
Chicken	Goat milk	Margarine/shortening	
Pork	Cheese	Fried foods	
Eggs	Butter	Yogurt or ice cream	
Fish	Sushi or raw meat		
Brown or white rice	Wheat bread	Oats	Nuts and/or seeds
Amaranth	White pasta	Beans	Nut butters
Quinoa	Wheat pasta	Tofu or tempeh	Tahini
Buckwheat	White pasta	Miso	

Like (+) or dislike (-):

Spicy _____
Bitter _____
Salty _____
Sweet _____
Sour _____

Please list vegetables you usually eat:

Please list fruits you usually eat:

FOR OFFICE USE ONLY:

Previously:

Habits/Appetite:

Allergies/Foods can't tolerate/Hate:

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