HEALTH HISTORY

Name: ________________________________ DOB: ____________________ Date: ______________________

Occupation: ____________________________ Weight: ______ Height: ________ Gender: ______ Number of Children: __________

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _______

Referred by: ____

List of current health problems for which you are being treated: ______________________________________

____

Reason for initial visit: ____

Name of GP/Specialists: ____

What types of therapies have you tried for these problem(s) or to improve your health overall:
☐ diet modification ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ massage ☐ acupuncture ☐ OTC/prescription drugs
☐ other ____

Do you experience any of these general symptoms on a regular basis?

☐ allergies
☐ bruising
☐ chronic pain/inflammation
☐ constipation
☐ cough
☐ depression
☐ diarrhea
☐ disinterest in sex
☐ dizziness
☐ fatigue
☐ food cravings
☐ gas/bloating
☐ hair loss
☐ headaches
☐ insomnia
☐ intolerance to extreme temperatures
☐ irritated bowel
☐ nausea
☐ panic attacks
☐ shortness of breath
☐ skin issues
☐ urinary incontinence
☐ vomiting
☐ water retention

Current prescription or over-the-counter medications: ***(Please bring them with you to your appointment)***: ______________________

____

Please bring any lab work from within the last 12 months including blood, urine, saliva, and hair analysis.

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

Year	Surgery, Illness, Injury	Outcome
______	____________________________________	____________________
______	____________________________________	____________________
______	____________________________________	____________________
______	____________________________________	____________________

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., family, changes in job/work, residence or 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 (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. fireman, etc.)? ____

What are your current health goals: ____

Natural Strategies for Vibrant Living

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, elevated
- ☐ 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
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other ______________________

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Erectile Dysfunction
- ☐ 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 __________

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, light) __________

☐Surgical menopause

☐Menopause

Family Health History (Parents and 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 day/wk ________

Liquor: #ounces day/wk ________

Beer: #bottles day/wk _________

☐ Caffeine:

Coffee: #6 oz cups/day ________

Tea: #6 oz cups/day___________

Soda w/caffeine: #cans/day ____

Other sources_______________

☐ Water: #glasses/day ________

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk - #days/wk ___________
- ☐ Run, jog, other aerobic - #days/wk ________________
- ☐ Weight lift - #days/wk ______
- ☐ Stretch (Yoga) - #days/wk ___

Other ______________________

____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ gluten ☐ eggs

☐ soy ☐ corn ☐ nuts

Other ______________________

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc)______

Dark green or deep yellow/orange vegetables ______________

Grains ______________________

Beans, peas, legumes _________

Dairy, eggs __________________

Meat, poultry, fish ____________

Desserts/Sweets _____________

Eating Habits

Skip meals – which ones _______

- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Vitamin E
- ☐ EFA/Fish Oil
- ☐ Calcium
- ☐ Magnesium
- ☐ Iron
- ☐ Minerals, describe__________ ____________________________
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)

Other ______________________

____

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 fewer colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications
- ☐ 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 handle 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 my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

Signed Disclaimer