HEALTH HISTORY

NAME: _____DATE: _____

DATE OF BIRTH: _____AGE: _____WEIGHT: _____ HEIGHT: _____

Top three health concerns you'd like to address:
1._____
2._____
3._____

Do you smoke? _____ How much/For how long? _____ Quit? When? _____
Do you drink alcohol? _____ How much/How often? _____
Do you drink caffeine? _____ How much/ How often? _____
Do you ever overeat? _____ If so, which foods and how often? _____
_____
Do you have food allergies, restrictions, or sensitivities? _____
_____
Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while?
_____
Do you crave certain foods? _____ If so, which foods and when? _____
_____
Who does the cooking?_____
How is food prepared?_____
How often do you eat out and where?_____
How many times a day do you eat _____ What times do you eat during the day?_____
Do you take any nutritional supplements or vitamins? _____ If so, which ones?
_____
_____
Which prescription and over the counter medications do you take regularly?
_____
_____
_____
Which oils do you use/consume?
□ Butter □ Peanut Oil □ Canola □ Margarine □ Corn Oil □ Sun/Safflower
□ Olive Oil □ Crisco □ Mayonnaise □ Coconut Oil □ Vegetable Oil □ Flaxseed Oil
□ Soybean Oil □ Other/s_____
How often do you consume: sugar substitutes_____ sugary beverages_____ vegetables_____
"junk food"_____ fried food _____ fruit_____ red meat_____ dairy _____
Describe your dental health? _____
Do you floss?_____ How often?_____ Frequency of dental visits: _____
Do you have amalgam fillings/root canals?_____ Have you had amalgams removed? When?_____
How many bowel movements do you have a day?_____ Describe:_____
Do you have any of the following: gas bloating heartburn constipation diarrhea
stomach pain nausea belching after meals
Do you exercise? _____ If so, what kind? _____
How often: Since when? _____

Please rate the following:

Daily energy level:	□ Excellent	□ Good	□ Fair	□ Poor
Energy level after exercise:	□ Excellent	□ Good	□ Fair	□ Poor
Daily stress level:	□ Very High	□ High	□ Moderate	□ Low

Do you have a support system of family and friends? _____
General enjoyment of life: □ Excellent □ Good □ Fair □ Poor

How many hours do you sleep? _____ Do you sleep throughout the night? _____
Do you wake up without an alarm? _____ Do you wake up feeling rested? _____
Do you fall asleep within 15 minutes? _____ How many nights a week do you sleep through the night? _____

Rank your skin without lotion: □ Very Dry □ Dry □ Normal □ Oily □ Combination

Please check off any of the following that pertain to you now or in the past.
(Please mark Present conditions with a P next to it):

- ☐ Acne
- ☐ Addiction (alcohol, drugs)
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Anxiety or nervousness
- ☐ Arthritis (Rheumatoid or Osteo)
- ☐ Asthma
- ☐ Bladder infections (Cystitis)
- ☐ Bloating, gas or indigestion
- ☐ Blood Sugar problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Colds or flu (frequent)
- ☐ Cold Sores
- ☐ Chronic fatigue
- ☐ Constipation
- ☐ Dandruff
- ☐ Depression
- ☐ Diabetes I (year onset?)_____
- ☐ Diabetes II (year onset?)_____
- ☐ Difficulty losing weight
- ☐ Difficulty gaining weight
- ☐ Emotional problems (instability or sensitivity)
- ☐ Emphysema
- ☐ Fainting
- ☐ Gall bladder problems
- ☐ Gout
- ☐ Hair loss or poor hair growth
- ☐ Headaches
- ☐ Heart disease or problems
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Herpes simplex or type II
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hot flashes
- ☐ Hypoglycemia
- ☐ Insomnia
- ☐ Intestinal problems
- ☐ Kidney stones
- ☐ Liver problems
- ☐ Loose stools
- ☐ Memory loss or confusion
- ☐ Nails, poor growth
- ☐ Panic attacks
- ☐ Parasites
- ☐ PCOS
- ☐ Pregnant or nursing mother
- ☐ Respiratory problems
- ☐ Ringing in ears
- ☐ Seizures
- ☐ Severe mood swings
- ☐ Skin conditions
- ☐ Stroke
- ☐ Suicidal tendencies
- ☐ Thyroid condition
- ☐ Ulcer
- ☐ Yeast infections

Women: Please check all that pertain:

- ☐ PMS
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Loss of periods
- ☐ Hormone Replacement Therapy
- ☐ Birth control pills
- ☐ Menopause
- ☐ Painful intercourse
- ☐ Children
- ☐ Hysterectomy
- ☐ Miscarriages

Men: Please check all that pertain:

- ☐ frequent urination
- ☐ Difficulty urinating
- ☐ Difficulty with erection
- ☐ Loss of libido
- ☐ Prostate enlargement

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____
_____
_____

Personal weight loss history: How many diets have you been on? _____
Which ones? _____
What were your results?
_____
Have you ever taken weight loss supplements or “diet pills”? _____

What do you feel triggered your initial weight gain/loss? (Circle One)

HEREDITY	EATING HABITS	STRESS	HORMONES
BOREDOM	SMOKING CESSATION	OTHER _____	

Was your weight gain/loss: (Circle One)

SUDDEN	GRADUAL	PROBLEM SINCE CHILDHOOD

Highest adult wt (year and wt)?_____ Lowest adult wt/when (year and wt)? _____

3 DAY DIET RECALL

Record everything that you eat and drink. Be as specific as possible as to size/amount of portion. Indicate how hungry you were and what you were doing while eating (i.e.: watching TV, driving, standing, talking, etc…)

DAY 1	***DAY 2***	***DAY 3***
BREAKFAST	**BREAKFAST**	**BREAKFAST**
MID-MORNING SNACK	**MID-MORNING SNACK**	**MID-MORNING SNACK**
LUNCH	**LUNCH**	**LUNCH**
AFTERNOON SNACK	**AFTERNOON SNACK**	**AFTERNOON SNACK**
DINNER	**DINNER**	**DINNER**
AFTER DINNER SNACK	**AFTER DINNER SNACK**	**AFTER DINNER SNACK**