

## HEALTH HISTORY

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
 Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

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

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit: \_\_\_\_\_ Date began: \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): \_\_\_\_\_

Outcome \_\_\_\_\_

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs  
☐ other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

Current medications (prescription or over-the-counter): \_\_\_\_\_

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., 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, farmer, miner)? \_\_\_\_\_

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ Prefer warmth (i.e., food, drinks, weather, etc.) ☐ Prefer cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Time of day you feel the worst or your symptoms are aggravated:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.  
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.  
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.  
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Time of day you feel the most energy or the least symptoms are aggravated

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.  
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.  
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.  
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation  
☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding  
☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge  
☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

**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  
☐ Sexually transmitted disease  
☐ Seasonal affective disorder  
☐ Skin problems  
☐ Tuberculosis  
☐ Ulcer  
☐ Urinary tract infection  
☐ Varicose veins  
 Other \_\_\_\_\_

**Medical (Men)**

- ☐ Benign prostatic hyperplasia (BPH)  
☐ Prostate cancer

- ☐ Decreased sex drive  
☐ Infertility  
☐ 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 \_\_\_\_\_  
 Age of first period \_\_\_\_\_  
 Date of last gynecological exam \_\_\_\_\_  
 Mammogram ☐ + ☐ -  
 PAP ☐ + ☐ -  
 Form of birth control \_\_\_\_\_  
 # of children \_\_\_\_\_  
 # of pregnancies \_\_\_\_\_  
☐ C-section \_\_\_\_\_  
☐ Surgical menopause  
☐ Menopause  
 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, scanty)

**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/d or wk \_\_\_\_\_  
 Liquor: #ounces/d or wk \_\_\_\_\_  
 Beer: #glasses/d or wk \_\_\_\_\_  
☐ Caffeine:  
 Coffee: #6 oz cups/d \_\_\_\_\_  
 Tea: #6 oz cups/d \_\_\_\_\_  
 Soda w/caffeine: #cans/d \_\_\_\_\_  
 Other sources \_\_\_\_\_  
☐ Water: #glasses/d \_\_\_\_\_

**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  
☐ Run, jog, jump rope  
☐ Weight lift  
☐ Swim  
☐ Box  
☐ Yoga

**Nutrition & Diet**

- ☐ Mixed food diet (animal and vegetable sources)  
☐ Vegetarian  
☐ Vegan  
☐ Salt restriction  
☐ Fat restriction  
☐ Starch/carbohydrate restriction  
☐ The Zone Diet  
☐ Total calorie restriction  
 Specific food restrictions:  
☐ dairy ☐ wheat ☐ eggs  
☐ soy ☐ corn ☐ all gluten  
 Other \_\_\_\_\_

**Food Frequency**

- Number of servings per day: \_\_\_\_\_  
 Fruits (citrus, melons, etc.) \_\_\_\_\_  
 Dark green or deep yellow/orange vegetables \_\_\_\_\_  
 Grains (unprocessed) \_\_\_\_\_  
 Beans, peas, legumes \_\_\_\_\_  
 Dairy, eggs \_\_\_\_\_  
 Meat, poultry, fish \_\_\_\_\_

**Eating Habits**

- ☐ Skip breakfast  
☐ Two meals/day  
☐ One meal/day  
☐ Graze (small frequent meals)  
☐ Food rotation  
☐ Eat constantly whether hungry or not  
☐ Generally eat on the run  
☐ Add salt to food

**Current Supplements**

- ☐ Multivitamin/mineral  
☐ Vitamin C  
☐ Vitamin E  
☐ EPA/DHA  
☐ Evening Primrose/GLA  
☐ Calcium, source \_\_\_\_\_  
☐ Magnesium  
☐ Zinc  
☐ Minerals, describe \_\_\_\_\_  
☐ Friendly flora (acidophilus)  
☐ Digestive enzymes  
☐ Amino acids  
☐ CoQ10  
☐ Antioxidants (e.g., lutein, resveratrol, etc.)  
☐ Herbs - teas  
☐ Herbs - extracts  
☐ Chinese herbs  
☐ Ayurvedic herbs  
☐ Homeopathy  
☐ Bach flowers  
☐ Protein shakes  
☐ Superfoods (e.g., bee pollen, phytonutrient blends)  
☐ Liquid meals  
 Other \_\_\_\_\_

**Would you like to:**

- ☐ Have more energy  
☐ Be stronger  
☐ Have more endurance  
☐ Increase your sex drive  
☐ Be thinner  
☐ Be more muscular  
☐ Improve your complexion  
☐ Have stronger nails  
☐ Have healthier hair  
☐ Be less moody  
☐ Be less depressed  
☐ Be less indecisive  
☐ Feel more motivated  
☐ Be more organized  
☐ Think more clearly and be more focused  
☐ Improve memory  
☐ Do better on tests in school  
☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.  
☐ Stop using laxatives or stool softeners  
☐ Be free of pain  
☐ Sleep better  
☐ Have agreeable breath  
☐ Have agreeable body odor  
☐ Have stronger teeth  
☐ Get less colds and flus  
☐ Get rid of your allergies  
☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)