Health History Form

Name_____

Address_____

City_____

State_____

Zip Code_____

Phone _____

Email_____

Referred by_____

Age _____

Birth Date _____

Gender _____

Height _____

Blood Type_____

Birth Weight (if known) _____

Delivery Method (e.g., c-section, natural birth) _____

Were you breastfed? For how long? _____

Current Weight _____

Ideal Weight _____

Weight One Year Ago _____

Family/Living Situation _____

Children _____

Occupation _____

Exercise/Recreation _____

History

1. Have you lived or traveled outside of the United States? If so, when and where?

_____

2. Have you or your family recently experienced any major life changes? If so, please comment:

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3. Have you experienced any major losses in life? If so, please comment:

_____

4. How much time have you had to take off from work or school in the last year?

○0 to 2 days

○3 to 14 days

○ More than 15 days

Health Concerns

5. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

6. When did you first experience these concerns?

7. How have you dealt with these concerns in the past?

○doctors

○self-care

8. Have you experienced any success with these approaches?

9. What other health practitioners are you currently seeing? List name, specialty and phone # below.

10. How often did you take antibiotics in infancy/childhood?

11. How often have you taken antibiotics as a teen?

12. How often have you taken antibiotics as an adult?

13. List any medicine you are currently taking:

14. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

15. Have any other family members had similar problems (describe)?

Nutritional Status

16. Are there any foods that you avoid because of the way they make you feel: If yes, please name the food and the symptom.

17. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives: If so, please explain:

18. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

19. Are there foods that you crave: If so, please explain:

20. Describe your diet at the onset of your health concerns:

21. Do you have any known food allergies or sensitivities?

22. Which of the following foods do you consume regularly?

○soda

○diet soda

○refined sugar

○alcohol

○fast food

○gluten (wheat, rye, barley)

○dairy (milk, cheese, yogurt)

○coffee

23. Are you currently on a special diet?

○ovo-lacto

○diabetic

○dairy restricted or dairy-free

○vegetarian

○vegan

○paleo

○blood type

○raw

○refined sugar-free

○gluten-free

○Other (please describe)

24. What percentage of your meals are home-cooked? ○ 10 ○ 20 ○ 30 ○ 40 ○ 50 ○ 60 ○ 70 ○ 80 ○ 90 ○ 100

25. Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

26. Bowel Movement Frequency ○ 1-3 times per day

○ more than 3 times per day ○ not regularly every day

27. Bowel Movement Consistency ○ soft & well formed

○ often float

○ difficult to pass ○ diarrhea

○ thin, long or narrow ○ small and hard

○ loose but not watery

○ alternating between hard and loose

28. Bowel Movement Color ○ medium brown

○ very dark or black ○ greenish

○ blood is visible ○ variable

○ yellow, light brown ○ chalky colored

○ greasy, shiny

29. Do you experience intestinal gas: If so, please explain if it is excessive, occasional, odorous, etc.?

Medical Status

30. Please check any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

○Cancer

○Heart Disease

○Hepatitis

○Venereal Disease

○Diabetes

○High Blood Pressure

○High Cholesterol

○Kidney Disease

○Thyroid Disease

○Depression

○Asthma

○Allergies

○Anemia

○Chronic Yeast Infections

○Other

Health Hazards

31. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

32. Do odors affect you?

33. Are you or have you been exposed to second-hand smoke?

34. Do you have mercury amalgam fillings?

35. Have you received vaccinations? As an adult?

Lifestyle History

36. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

37. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

38. How do you handle stress?

39. Describe your sleep patterns. Can you get to sleep easily? Can you stay asleep? How many hours do you average per night?

For Women Only

40. How are/were your menses? Do/did you have PMS? Painful periods: If so, explain.

41. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

42. Have you experienced any yeast infections or urinary tract infections? Are they regular?

43. Have you/do you still take birth control pills: If so, please list length of time and type.

44. Have you had any problems with conception or pregnancy?

45. Are you taking any hormone replacement therapy or hormonal supportive herbs: If so, please list again here.

Mental Health Status

46. How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?

47. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.
48. At what point in your life did you feel best? Why?
Other
49. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.
50. Who in your family or on your health care team will be most supportive of you making dietary change?
51. Please describe any other information you think would be useful in helping to address your health concern(s):
52. What are your health goals and aspirations?
53. Though it may seem odd, please consider why.