HEALTH HISTORY

PERSONAL

First Name: _____

Last Name: _____

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

Email: _____

How often do you check your email?: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Current Weight: _____ Weight 6 Months Ago: _____

Weight 1 Year Ago: _____

Would you like your weight to be different? _____

If so, how? _____

SOCIAL

Relationship Status: _____

Where to you live? _____

Any children?: _____ Any pets?: _____

Occupation: _____

How many hours do you work per week? _____

GENERAL HEALTH

What are your main health concerns?

_____

_____

_____

_____

_____

Any other concerns and/or goals?

_____

_____

_____

_____

_____

At what point in your life did you feel your best?

_____

Any current or previous serious illnesses, hospitalizations, or injuries?

_____

_____

How is/was your mother's health?

_____

How is/was your father's health?

_____

What is your ancestry? _____ What is your blood type? _____

How is your sleep? _____

How many hours do you sleep per night? _____

Do you wake up during the night? If so, why?

_____

Any pain, stiffness, or swelling? _____

Any constipation, diarrhea, or gas? _____

Any allergies or sensitivities? _____

MEDICAL

List all supplements or medications:

_____

_____

_____

_____

_____

Are you presently receiving alternative treatment therapies ?
ie massage ,acupuncture, herbal medicine, etc.

_____

_____

_____

_____

_____

What role do sports and exercise play in your life?

_____

_____

_____

_____

_____

FOOD

Will your family and friends be supportive of your desire to make food and/or lifestyle changes?

_____

Do you cook? _____

What percentage of your food is home-cooked? _____

Where does your non-home-cooked food come from? _____

What foods did you eat often as a child?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____

What foods do you typically eat these days?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____

Do you crave sugar, coffee, or cigarettes? Do you have any other major addictions?

_____

_____

What is the most important thing you would like to change in your diet right now?

_____

_____

_____

ADDITIONAL COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____