Adult Health History

Please answer all applicable questions to the best of your knowledge. We look forward to working with you.

Client Name:_______________________________ Age:________ Date of Birth:______________

Occupation:______________________ Employer:__________________________ Work Hours/Week:_______

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ With Partner ❑ Widower

Do you have children? ❑ Y ❑ N If 'yes,' how many?_________________________________

Highest Level of Education: ❑ High School ❑ Some College ❑ College Graduate ❑ Graduate School

Insurance Company:______________________ Policy:____________________ Group #:__________________

Name of Insured: ____________________________________ Relation to Insured:______________________

Social Security Number:________________________________

Person to call in case of Emergency:______________________ Relationship:_____________________________

Emergency Contact Phone Number:____(____)_____________________

Regular Physician:____________________________________ Phone Number: (____)____________________

How Did You Hear About Us? ❑ Referral ❑ Web Search ❑ Email ❑ Facebook ❑ Advertisement ❑ Event

Other - ____

CURRENT HEALTH PICTURE

What are your main health concerns/reasons for your visit? (Please List in Order of Importance)

1. ____ Date First Noticed or Diagnosed: ____________
2. ____ Date First Noticed or Diagnosed: ____________
3. ____ Date First Noticed or Diagnosed: ____________
4. ____ Date First Noticed or Diagnosed: ____________
5. ____ Date First Noticed or Diagnosed: ____________

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Please list any Additional Questions or Expectations of the appointment today.

The general state of your health is (please circle one): ❑ Excellent ❑ Good ❑ Average ❑ Fair ❑ Poor

Are you currently seeing (a) medical specialist (s)? ❑ Y ❑ N If yes, for what reason?

When was the last time you had blood work or other lab testing performed?(month/year):

What type of testing was performed?:

Is this your first time working with a Holistic Nutritionist for any of your main health concerns? ❑ Y ❑ N

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living						
Age when died						
Reason for death						
Cancer (any type)	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
High Blood Pressure	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Heart Attack/Stroke	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Heart Disease	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Asthma/Allergies	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Mental illness	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Drug or Alcohol Addiction	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Auto-immune disease	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Diabetes Mellitus	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N
Osteoporosis	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N	❑Y ❑N

List any other pertinent family information in the space below:

4 Considerations – Scar Tissue

List All Surgeries and Reasons for Hospitalizations (Include any cosmetic procedures):

1. ______________________________ Date: ________ 2. ______________________________ Date: ________

3. ______________________________ Date: ________ 4. ______________________________ Date: ________

5. ______________________________ Date: ________ 6. ______________________________ Date: ________

List All Accidents, Injuries, or Physical Traumas:

1. ______________________________ Date: ________ 2. ______________________________ Date: ________

3. ______________________________ Date: ________ 4. ______________________________ Date: ________

5. ______________________________ Date: ________ 6. ______________________________ Date: ________

Please Note When and Why You Had Each of The Following:

X-rays: ____

MRI/Cat Scans: ____

Ultrasounds: ____

4 Considerations – Acidic pH

Please Mark Any of the Following You Feel Apply to You:
❑ dark circles under the eyes ❑ acne ❑ eczema ❑ history of asthma/sinusitis ❑ history of hernias
❑ history of irritable or inflammatory bowel ❑ history of acid reflux ❑ history of migraines
❑ history of ear itching/infections ❑ fatigue 2+ hours after eating ❑ itchy eyes ❑ nosebleeds
❑ sore throat/stiff neck

Please List All Sensitivities/Allergies/Reactions:

Drugs: ____

Foods: ____

Environmental: ____

❑ red eyes ❑ sensitive skin ❑ myxedema ❑ zinc spots on nails ❑ brittle nails/hair ❑ multiple broken bones
❑ clear urine ❑ arthritis ❑ easy bruising ❑ slow reflexes/recall ❑ cavities ❑ high blood pressure
❑ low blood pressure ❑ heart palpitations ❑ kidney stones

❑ constipation ❑ clay colored stools ❑ diarrhea ❑ nausea ❑ vomiting ❑ acid reflux ❑ hemorrhoids
❑ hernias ❑ flatulence ❑ rectal bleeding ❑ rectal itching ❑ history of ulcers ❑ mucus in stools
❑ alternating diarrhea & constipation ❑ undigested food in stools

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List All Travel Outside of the US Over Last 5 Year?____

____

Have you consumed any untreated river water while hiking or camping? ❑Y ❑N

Have you ever done a Colon or Liver Cleanse? ❑Y ❑N If 'yes,' when was your last one? ____________

Have you ever fasted? ❑Y ❑N If 'yes,' when was your last one? ________________________

How many rounds of antibiotics have you had within the last year? _____ 5 years? ______ Lifetime? ____________

List Yes, No, or Past regarding use of the following:

Antacids:	❑Y ❑N ❑P	Laxatives:	❑Y ❑N ❑P
Analgesics:	❑Y ❑N ❑P	Steroids:	❑Y ❑N ❑P
Recreational drugs:	❑Y ❑N ❑P	Any drug treatment:	❑Y ❑N ❑P
Cigarettes:	❑Y ❑N ❑P	Packs per day:________________	
Marijuana:	❑Y ❑N ❑	Days per week:_______________	
Alcohol:	❑Y ❑N ❑P	Days per week:_______________	
Coffee:	❑Y ❑N ❑P	Cups per day:________________	
Soda Pop:	❑Y ❑N ❑P	Ounces per day:______________	

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	❑D ❑I ❑N	Diphtheria:	❑D ❑I ❑N
Mumps:	❑D ❑I ❑N	Tetanus:	❑D ❑I ❑N
Rubella:	❑D ❑I ❑N	Whooping Cough:	❑D ❑I ❑N
Chickenpox:	❑D ❑I ❑N	Hemophilus (Hib):	❑D ❑I ❑N
German Measles:	❑D ❑I ❑N	Hepatitis B:	❑D ❑I ❑N

Any vaccination reactions: ____

Medications: Please give full name, dosage, and length of time that you have been taking medication

Pharmaceuticals	Dose	When/ How often

Supplements/Herbs	Dose	When/ How often

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:______________________________

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____
____

Have you ever experienced shortness of breath, memory fog, fainting, or any peculiar symptoms after installing new carpet, paint, furnishings, or any other home refurbishing?:______________________________
____

Are you particularly sensitive to perfumes, gasoline, or other vapors?:______________________________

Do you use pesticides, herbicides, other chemicals around your home?______________________________

How many amalgam 'silver' filings do you have? _______

Perspiration has Odor: ❑ Y ❑ N

4 Considerations – Emotional Charge

Please Mark Any of the Following You Feel Apply to You:

❑ unworthy ❑ resistant to change ❑ accepting of defeat ❑ busy as escape ❑ excessive concentration

❑ mental chatter ❑ easily overwhelmed ❑ grieving ❑ keeping it inside ❑ can't let go ❑ lack of trust

❑ afraid/worried/anxious ❑ angry ❑ indecisive ❑ frustrated/impatient ❑ complaining ❑ timid ❑ alone

❑ isolated ❑ neglected ❑ guilt ❑ excessive thought/second guessing self

Have you ever been witness to or subjected to acts of physical violence, abuse or emotional trauma? ❑ Y ❑ N

If 'yes' please list at what age(s)?______________________________

Have you ever been in a serious accident or injured in life-threatening situation? ❑ Y ❑ N

If 'yes' please list at what age(s)?______________________________

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Stress History: Please list the 5 most significant, stressful events/relationships/situations in your life.

1. ____ Date________________
2. ____ Date________________
3. ____ Date________________
4. ____ Date________________
5. ____ Date________________

How many hours do you sleep each night? _____ How long does it take you to get to sleep? _____

Do you sleep through the night uninterrupted? ❑ Y ❑ N Do You Dream? ❑ Y ❑ N

If you wake, what is the time & reason: ____

Nightmares: ❑ Y ❑ N Do you wake feeling refreshed? ❑ Y ❑ N

Grind Teeth: ❑ Y ❑ N Do you Snore? ❑ Y ❑ N

Present Weight:_______________lbs Weight One Year Ago:__________lbs Ideal Weight:_____________lbs

Maximum weight as adult and when:__________ Minimum Weight as adult and when:_________

Height: _______ft______in

On average, describe your energy level from 1-10 Waking? _____ Evening? _____ (10 = high, 1 = very low energy)

On average, describe your happiness level from 1-10? _____ (10 = very, very happy)

Average Number of Bowel Movements per Day? _______ Number of Days Each Week without a BM? ______

Regularly Feel Energetic: ❑ Y ❑ N

Regularly Feel Fatigue: ❑ Y ❑ N

If you have fatigue, when is it the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ After Eating

If you have fatigue, can you do what you need to during the day (ie for work/family)? ❑ Y ❑ N

4 Considerations – Biomechanical Misalignment

❑ back pain ❑ shoulder pain ❑ neck pain ❑ sciatica ❑ carpal tunnel syndrome ❑ TMJ syndrome
❑ numbness ❑ tingling ❑ seizures ❑ muscle pain that moves from place to place

How often do you Practice Yoga or some alternate form of therapeutic stretching? _____ Days per Week

How often do you use Cardiovascular Exercise? ________ Days per Week. For How Long? _______ Minutes

How often do you get massaged? ______ Times Per Month

General History

Sexually Active: ❑ Y ❑ N
Healthy Libido: ❑ Y ❑ N
Sexually Satisfied: ❑ Y ❑ N
What Hobbies/Interest Bring You The Most Happiness? ____

____

Are you working with a professional counselor, psychologist, social worker, pastor, or other therapist? ❑ Y ❑ N
Are you happy with your spiritual practice? ❑ Y ❑ N Active? ❑ Y ❑ N
Do you enjoy your job? ❑ Y ❑ N

If Applicable - Female Reproductive:
Do You Know How to Identify Genital Warts on your partner? ❑ Y ❑ N

If Menopausal at what age did it occur?________
Times Pregnant:_______ How many births:_____ Miscarriages:_____ Abortions:_____
Any Difficulty Getting Pregnant? ❑ Y ❑ N

Age periods began: ______ Periods occur every: _____days Periods last: _____days
Are her periods? ❑ regular(4-6 days) ❑ long ❑ short ❑ none
Menstrual Flow? ❑ regular ❑ heavy ❑ scant
What color is the blood? ❑Light ❑ Medium ❑ Dark Red
Spotting or bleeding in between periods? ❑ Y ❑ N

Clots?	❑ Y ❑ N	Food Cravings:	❑ Y ❑ N
Cramping:	❑ Y ❑ N	Pain:	❑ Y ❑ N
PMS:	❑ Y ❑ N	Pelvic Pain:	❑ Y ❑ N

PMS Symptoms where relevant:
❑ Water Retention ❑ Breast Tenderness ❑ Irritability ❑ Headaches ❑ Depression ❑ Mood Swings

Do you perform monthly Self-Breast Exams? ❑ Y ❑ N
Last Pap Smear:___________________________________
Diagnosis:____

Pain With Intercourse: ❑ Y ❑ N
Dry Vagina: ❑ Y ❑ N
Vaginitis: ❑ Y ❑ N

_______**I understand that the extent to which my health goals are successful will be determined by the amount of energy, commitment, and dedication I give to support the work I am endeavoring into.**

_______**I accept responsibility for my health.**