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Because real health starts from within

Confidential Health History Form

Full name: _____

Address: _____

Email address: _____

Cell: _____

Age: _____Height:_____Date of Birth:_____Place of Birth:_____

Current weight:_____Weight six months ago:_____ One year ago:_____

Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____

Children: Pets: Grandchildren:

Occupation/ main recreational activity : _____

Hours of work per week: _____

Do you have a strong community of friends and/or family around? _____

Please list your main health concerns:

_____

_____

_____

Other concerns and/or goals? _____

What is your stress level 1-10 (1 very low stress 10 very high stress) _____

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

Any serious illnesses/hospitalizations/injuries? _____

Childhood Vaccines? Y/N_____ Which ones? _____

_____

Vaccines as an adult Y/N_____Which ones? _____

COVID vaccine? Y/N_____ How many? _____ Date of the last one_____

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Flu vaccine? Y/N_____

Date of the last one_____

Amalgam fillers? Y/N _____

Exposure to environmental toxins? Y/N____ Circle the ones that apply- scented candles, perfume, commercial laundry detergent, house cleaning products, mold, Radiation, EMF, other _____

Did you receive antibiotics at some point in your life? Y/N When? _____

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry? _____

Do you sleep well? _____How many hours? _____ do you wake up at night?_____Why?_____

_____

Any pain, stiffness or swelling? _____

Constipation/Diarrhea/Gas? Please explain: _____

Allergies or sensitivities? Please explain: _____

Do you take any supplements or medications? Please list: _____

_____

Any healers, helpers, or therapies with which you are involved? Please list: _____

_____

What role does sports and exercise play in your life? _____

What foods did you eat often as a child?

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Liquids_____

What's your food like these days?

Breakfast_____

Lunch_____

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Dinner_____

Snacks_____

Liquids_____

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

What percentage of your food is home-cooked? _____ Do you cook? _____

Where do you get the rest from? _____

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

_____

How much water do you drink per day? _____

How many times a day/ week you poop?_____ Solid / liquid?_____

Easy stool Yes/No? _____

Do you follow a certain diet or restrictions? _____

What time you finish dinner? _____

What time do you go to sleep? _____

The most important thing I should change about my diet to improve my health is: _____

_____

Anything else you want to share? _____

_____

_____