HEALTH HISTORY

Name _____ Date _____

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:

_____ _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

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

Current medications (prescription or over-the-counter): _____

_____

_____

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

_____

Outcome _____

_____

_____

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, etc.)?

_____

What are your current health goals: _____

_____

_____

_____

_____

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
- ❑ 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 _____

Date of last GYN exam _____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

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) _____

- ❑ Surgical menopause
- ❑ Menopause

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 - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk _____
- ❑ Weight lift - #days/wk _____
- ❑ Stretch - #days/wk _____
- ❑ Other _____

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 meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

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
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

7/00, Rev 1/03, Rev 3/06

MET1392

HEALTH APPRAISAL - BRIEF

NAME_____ DATE_____

CIRCLE the number which best describes the ***frequency*** of your symptoms. If you do not know the answer to the question, leave it blank. When you are finished, please add the number of points in each section and enter the number in the **Total Point** box. The score for YES is the number inside the parenthesis ( ).

(0) never or rarely (1) twice a week or less (2) three to six times a week (3) daily or several times a day

PART I

Section A

1. Indigestion	0	1	2	3
2. Belching, burping	0	1	2	3
3. Gas immediately following a meal	0	1	2	3
4. Sense of fullness during meals	0	1	2	3
5. Poor appetite, picky eater	0	1	2	3
6. Difficult bowel movements	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. History of anemia, unresponsive to iron	N			Y (10)
9. Vegetarian (no eggs, dairy)	N			Y (5)
10. Spoon shaped nails	N			Y (3)
11. Unintentional weight loss	N			Y (3)
12. Partial loss of taste or smell	N			Y (3)

Total Points_____

Section B

1. Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
2. Pain, tenderness, soreness on left side under rib cage	0	1	2	3
3. Bloated	0	1	2	3
4. Excessive passage of gas	0	1	2	3
5. Abdominal cramps, aches	0	1	2	3
6. Nausea and/ or vomiting	0	1	2	3
7. Specific foods/ beverages aggravate indigestion	0	1	2	3
8. Roughage and fiber causes constipation	0	1	2	3
9. Three or more large bowel movements daily	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Undigested food in stool	0	1	2	3
12. Mucus in stool	0	1	2	3
13. Dry, flaky skin, dry brittle hair	N			Y (3)
14. Difficulty gaining weight	N			Y (3)

Total Points_____

Section C

1. Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
2. Feeling hungry an hour or two after eating	0	1	2	3
3. Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
4. Heartburn, especially when lying down, bending forward	0	1	2	3
5. Heartburn due to spicy and fatty foods, chocolate, peppers, citrus, alcohol, caffeine	0	1	2	3
6. Difficulty or pain when swallowing	0	1	2	3
7. Chest pain or infections, difficulty breathing	0	1	2	3
8. Experience relief from carbonated beverages, cream/ milk/ food	0	1	2	3
9. Constipation	0	1	2	3
10. Black, tarry stool	0	1	2	3

Total Points_____

Section D

1. Lower abdominal pain, cramping and/ or spasms	0	1	2	3
2. Lower abdominal pain relief by passing stool or gas	0	1	2	3
3. Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
4. Diarrhea (loose watery stool)	0	1	2	3
5. More than three bowel movements daily	0	1	2	3
6. Excessive gas and bloating	0	1	2	3
7. Painful, difficult, straining during bowel movements	0	1	2	3
8. Hard, dry or small stool	0	1	2	3
9. Extremely narrow stools	0	1	2	3
10. Alternating diarrhea/ constipation	0	1	2	3
11. Mucus, pus in stool	0	1	2	3
12. Feeling that bowels do not empty completely	0	1	2	3
13. Bright red blood following bowel movement	0	1	2	3
14. Anal itching	0	1	2	3

Total Points_____

PART II

Section A

1. Moderate to severe pain under right side of rib cage	0	1	2	3
2. Abdominal pain worsens with deep breathing	0	1	2	3
3. Regurgitate bitter fluid	0	1	2	3
4. Bloated, full feeling	0	1	2	3
5. Belching, heartburn, gas	0	1	2	3
6. Fatty foods cause indigestion	0	1	2	3
7. Nausea or vomiting	0	1	2	3
8. Feel restless, agitated	0	1	2	3
9. Unexplained itchy skin worse at night	0	1	2	3
10. Stool color alternates from clay colored to normal brown	0	1	2	3
11. Feeling of poor health	0	1	2	3
12. Fatigue, weakness, exhaustion	0	1	2	3
13. Unable to concentrate, irritable, confused	0	1	2	3
14. Swollen feet and/ or legs	0	1	2	3
15. Easy bruising	0	1	2	3
16. Feeling of extreme dryness	0	1	2	3
17. Reddened skin, especially palms	0	1	2	3
18. Dark urine, diminished flow	0	1	2	3
19. Dry, flaky skin, hair	N			Y (3)
20. Yellowish cast to skin, eyes	N			Y (3)

Total Points_____

Section B

1. Fatigue, sluggish	0	1	2	3
2. Feel cold, (i.e. hands and feet)	0	1	2	3

Section B (continued)

3. Difficult, infrequent bowel movements	0	1	2	3
4. Dryness - skin, hair	0	1	2	3
5. Thick, brittle nails	0	1	2	3
6. Outer third of eyebrow thins	0	1	2	3
7. Puffy face, hands and feet	0	1	2	3
8. Swollen upper eyelids	0	1	2	3
9. Eyeballs move involuntarily	0	1	2	3
10. Muscles weak, cramp and/ or tremble	0	1	2	3
11. Slow mental processes, forgetfulness	0	1	2	3
12. Slow heart beats	0	1	2	3
13. Loss of appetite	0	1	2	3
14. Abdominal swelling	0	1	2	3
15. Unsteady gait, movements	0	1	2	3
16. Lack of interest in sex	0	1	2	3
17. Premenstrual tension	N			Y (3)
18. Infertility	N			Y (3)
19. Heavy menstrual bleeding	N			Y (3)
20. Gain weight easily	N			Y (10)
21. Swelling of the neck	N			Y (10)
22. Thinning hair on scalp, face and genitals	N			Y (3)

Total Points_____

PART III

1. Progressive, mild fatigue after exertion or stress	0	1	2	3
2. General weakness	0	1	2	3
3. Blurred vision, dizzy when rising	0	1	2	3
4. Depression	0	1	2	3
5. Rapid mood swings	0	1	2	3
6. Irritable, nervous	0	1	2	3
7. Dark circles under the eyes	0	1	2	3
8. Disinterest in food	0	1	2	3
9. Abdominal pain	0	1	2	3
10. Indigestion	0	1	2	3
11. Blotchy skin (white patches)	0	1	2	3
12. Tan skin, no sun	0	1	2	3
13. Black freckles on upper forehead, face, neck	0	1	2	3
14. Craving for salty foods	0	1	2	3
15. Gradual loss of body hair	N			Y (3)
16. Sensitive to subtle changes in surroundings, weather	N			Y (5)

Total Points_____

PART IV

Section A

1. Generalized bone tenderness and achiness	0	1	2	3
2. Localized bone pain	0	1	2	3
3. Bone deformity or swelling	0	1	2	3
4. Shins hurt during or after exercises	0	1	2	3
5. Low back or hip pain	0	1	2	3
6. Limp, walking difficulties	0	1	2	3
7. Crunching or creaking sounds when move joints	0	1	2	3
8. Hands, feet, throat spasm, feel numb	0	1	2	3
9. Joint pain and stiffness - especially in spine, hips, knees	0	1	2	3
10. Hearing loss, headaches, ringing in ears	0	1	2	3
11. Established bone loss	N			Y (10)
12. Calcium deposits	N			Y (5)
13. Spinal curvature	N			Y (10)
14. Recent loss of height	N			Y (10)
15. Bow legs	N			Y (5)
16. Stooped posture	N			Y (5)
17. Hump at base of neck	N			Y (5)
18. Unexplained bone fracture	N			Y (10)
19. Tooth loss, gum disease	N			Y (3)

Total Points_____

Section B

1. General muscle ache, pains	0	1	2	3
2. Localized muscle stiffness, tension, pain	0	1	2	3
3. Specific points on body feel sore when presses	0	1	2	3
4. Headaches	0	1	2	3
5. Fatigue, tired, sluggish	0	1	2	3
6. Difficulty sleeping	0	1	2	3
7. Feel unrefreshed upon awakening	0	1	2	3
8. Muscle weakness or loss	0	1	2	3
9. Difficulty speaking swallowing	0	1	2	3
10. Muscle cramps or spasm	0	1	2	3
11. Muscles twitch or tremble - eyelids, thumb, calf muscle	0	1	2	3
12. Irresistible urge to move legs	0	1	2	3

Section B (continued)

13. Legs move during sleep	0	1	2	3
14. Numbing, tingling sensation	0	1	2	3
15. Excessive joint mobility	0	1	2	3
16. Unable to fully straighten or extend legs and/ or arms	0	1	2	3
17. Upper or lower back pain	0	1	2	3

Total Points_____

Section C

1. Joint stiffness, soreness	0	1	2	3
2. Red, swollen painful joints	0	1	2	3
3. Joint stiffness worsens with rest, improves with moving	0	1	2	3
4. Cracking joints	0	1	2	3
5. Shooting, aching, tingling pain down the back of leg	0	1	2	3
6. Joint pain involves one or a few joints	0	1	2	3
7. Joints hurt when moving or when carrying weight	0	1	2	3
8. Limited range of motion	0	1	2	3
9. Difficulty standing up from sitting position	0	1	2	3
10. Joint stiffness improves with rest, worsens with moving	0	1	2	3
11. Headache	0	1	2	3
12. Difficulty chewing food or opening mouth	0	1	2	3
13. Numbness, prickling, tingling sensation in the neck, shoulder and arms	0	1	2	3
14. Involuntary muscle spasms	0	1	2	3
15. Deliberate movement with hands is difficult	0	1	2	3
16. Injure, strain, sprain easily	0	1	2	3
17. Discomfort or pain in neck, shoulder or arm	0	1	2	3
18. Knobby overgrowths on the joints closest to the fingertips	N			Y (5)
19. Double jointed	N			Y (5)
20. One leg shorter than the other	N			Y (5)

Total Points_____

Daily Food Diary

Date: _____ ***Day:*** _____

Breakfast:

Lunch:

Dinner:

Snacks:

Water:

Medications, Supplements & Probiotics:

Weekly Symptom Survey Results: _____

Today's Symptoms:

Additional Comments & Notes: