

# Your Health-Matters

*Transforming Lives One Bite at a Time*

## Men's Health History

Thank you for your interest in learning more about **Your Health-Matters** lifestyle and nutritional program. Please complete the **confidential** health and nutrition history form.

### PERSONAL INFORMATION

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Email: \_\_\_\_\_ How often do you check email? \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Current weight: \_\_\_\_\_ Weight six months ago: \_\_\_\_\_ One year ago: \_\_\_\_\_

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

### SOCIAL INFORMATION

Relationship status: \_\_\_\_\_

Where do you currently live? \_\_\_\_\_

Children: \_\_\_\_\_ Pets: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours of work per week: \_\_\_\_\_

### HEALTH INFORMATION

Please list your main health concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other concerns and/or goals? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Any serious illnesses/hospitalizations/injuries? \_\_\_\_\_

\_\_\_\_\_

**Men's Health History**

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**HEALTH INFORMATION** (continued)

How is/was the health of your mother? \_\_\_\_\_

How is/was the health of your father? \_\_\_\_\_

What is your ancestry? \_\_\_\_\_ What blood type are you? \_\_\_\_\_

How is your sleep? \_\_\_\_\_ How many hours? \_\_\_\_\_ Do you wake up at night? \_\_\_\_\_

Why? \_\_\_\_\_

Any pain, stiffness, or swelling? \_\_\_\_\_

Constipation/Diarrhea/Gas? \_\_\_\_\_

Allergies or sensitivities? Please explain: \_\_\_\_\_

**MEDICAL INFORMATION**

Do you take any supplements or medications? Please list: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

What role do sports and exercise play in your life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### FOOD INFORMATION

What foods did you eat often as a child?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What is your food like these days?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Will family and/or 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 do you get the rest from? \_\_\_\_\_

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

The most important thing I should do to improve my health is: \_\_\_\_\_

### ADDITIONAL INFORMATION

Anything else you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Thank you for taking the time to complete the confidential health and nutrition history form. I look forward to reviewing your form and recommending a health and nutritional program to meet your health goals and lifestyle.

I look forward to taking this health journey with you. I will share my expertise and guide you to transform your health, *one bite at a time*.

Yours in Health & Longevity,

*Colleen Neely* CINHC

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Your Health-Matters

Wellness Coordinator

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*Hippocrates 'Let Food be the Medicine and Medicine be thy Food'*