NATURALLY NOA

Because real health starts from within

Confidential Health History Form

Please write or print clearly.

Name:_____

Address:
_____

Email address:_____

Telephone – Work:_____ Home: _____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:_____

Occupation:_____Hours of work per week:_____

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? _____

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_____

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?_____

Do you follow a certain diet or restrictions?_____

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

_____

Anything else you want to share? _____

_____

_____