Health History

Name: _____ Date: _____

Birthdate: _____ Age: _____ Sex: ☐ Male ☐ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks

Are you: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

Names and ages of children: _____

How did you hear about the SHAPE Program? _____

What health benefits do you want to achieve with the SHAPE Program?

☐ Improved eating habits ☐ Improved well-being ☐ Decreased inflammation ☐ Weight loss
☐ Increased energy ☐ Improved sleep ☐ Increased stamina ☐ Other _____

Physical Health

Height: _____ Weight: _____

Are there any areas of your body that are not functioning optimally? ☐ Yes ☐ No

If yes, explain: _____

On average, how many hours do you sleep per night? ☐ <5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you wake up feeling refreshed? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No

If yes, why and when? _____

Have you been diagnosed with any clinical condition or disease? ☐ Yes ☐ No

If yes, what? _____

Have you ever been in a motor vehicle accident? ☐ Yes ☐ No

If yes, what kind and when? _____

Were you evaluated and treated after the accident? ☐ Yes ☐ No

Have you had any non-vehicle accidents or falls? ☐ Yes ☐ No

If yes, explain: _____

Have you had any imaging performed in the last year? ☐ X-ray ☐ MRI ☐ US ☐ PET ☐ No

Have you had blood work performed in the last year? ☐ Yes ☐ No

Were your test results in medically normal ranges? ☐ Yes ☐ No

If no, which results were abnormal? _____

Food Health

Please list the foods you commonly eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many cups of vegetables do you eat per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

What foods do you crave? _____

What are some specific goals you have regarding the SHAPE Program? _____

_____

Chemical Health

Do you choose to get annual vaccine shots? ☐ Yes ☐ No Specific: _____

Have you used antibiotics in the last year? ☐ Yes ☐ No

How many cups of water do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of coffee/energy drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of juice/soda/sports drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods)? ☐ Yes ☐ No

If yes, how many servings per day? _____

Do you eat refined sugar? ☐ Yes ☐ No

If yes, how many servings per day? _____

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum)? ☐ Yes ☐ No

Do you have any food/drink allergies, sensitivities or intolerances? ☐ Yes ☐ No _____

Do you smoke? ☐ Yes ☐ No ☐ I used it for: _____ years

Are you/have you been exposed to second-hand smoke? ☐ Yes ☐ No

Do you take probiotics? ☐ Yes ☐ No Do you take Vitamin D? ☐ Yes ☐ No

Do you take Omega-3? ☐ Yes ☐ No Other supplements: _____

Please list any medications that you take regularly and why: _____

_____

_____

Mental Well-Being Checklist

Check all that apply:	**1st eval.**	**2nd eval.**	**3rd eval.**	**4th eval.**
Date				
I feel bad about myself.				
I can't forgive myself or others.				
I think there's something wrong with me.				
I have too many bad habits and I can't seem to break them.				
When it comes to being healthy, I don't even know where to start.				
I don't have any willpower or real, lasting self-control.				
I am lonely and don't have any support.				
I'm afraid I don't have the ability to change.				
I cannot change the way I have lived my whole life.				
I have too much baggage.				
I tend to eat emotionally for any and every reason: happy, sad, anxious, mad, bored or empty.				
There is too much social pressure, I don't think I can handle it.				
I don't have anybody who cares about me; why should I care about myself?				
The mere thought of living without certain comforts makes me depressed.				
I've lost weight before, but I don't have discipline or strength to keep it off.				
I've been overweight my whole life; I'll never be able to lose it.				
I'm too overwhelmed to make any significant changes in my already too-stressful life.				
I have many painful things in my past that I am not sure I can face.				
I'm broken.				
On the outside, it looks like I'm fine; but in reality, I'm not all that together.				
It's all just too much.				

Notes: _____

_____

_____

_____

_____

What SHAPE is Your Health In? Questionnaire

Symptoms: Write the number that best describes how you have experienced each symptom over the last year:

0 = Never 3 = Sometimes 5 = Always

Acid reflux, heartburn		Eczema, psoriasis		Low blood sugar	
Acne		Erectile dysfunction		Low libido	
Anxiety		Excessive sweating		Mood swings	
Asthma		Excessive thirst/hunger		Muscle cramps, spasms	
Belching, passing gas		Fatigue, low energy		Muscle pain, aches, weakness	
Bleed or bruise easily		Food sensitivities/allergies		Nausea, vomiting	
Bloating		Frequent colds or flus		Nose bleeds	
Blurred or tunnel vision		Frequent need to clear throat		Painful or heavy periods	
Body odor		Gallbladder problems		Poor memory	
Breast masses or fibroids		Gout		Premenstrual syndrome (PMS)	
Brittle nails		Hair loss or thinning		Prostate problems	
Bronchitis		Hay fever, seasonal allergies		Rapid or pounding heartbeat	
Brown age/liver spots		Headaches, migraines		Skin rashes	
Chemical sensitivities		Hemorrhoids		Shortness of breath	
Chest congestion		High blood pressure		Sinus congestion or infection	
Chest pain or pressure		Hives		Sore throat, hoarseness	
Chronic coughing		Hot/cold intolerance		Stiffness, limited movement	
Cold/canker sores		Hyperactivity		Stuffy nose	
Constant sneezing		Incontinence		Swelling, edema	
Constipation		Indigestion		Swollen lymph nodes	
Cravings		Insomnia		Swollen tongue, gums or lips	
Cysts, boils		Intestinal or stomach pain		Tendonitis, bursitis	
Depression		Irregular, skipped heartbeat		Tinnitus, hearing loss	
Diarrhea		Irregular periods		Ulcers	
Difficulty breathing		Irritable when hungry		Urinary tract problems	
Difficulty concentrating		Itchy ears		Vaccine reactions	
Difficulty falling/staying asleep		Itchy skin, dermatitis		Vaginal discharge	
Difficulty losing weight		Joint pain		Varicose veins	
Dizziness, faintness		Kidney stones		Watery or itchy eyes	
Ear drainage		Low back pain		Weight gain	
Earaches, ear infections		Low blood pressure		Yeast infections	

ADD/ADHD		Diabetes		Hepatitis, liver disease	
Anxiety		Eczema, psoriasis		Hypoglycemia	
Arthritis		Fibromyalgia		Infertility	
Asthma		GERD		Insulin resistance	
Autoimmune conditions		Gout		Irritable bowel syndrome	
Celiac disease		Gouty arthritis		Restless leg syndrome	
Colitis, Crohn's disease		Hay fever, seasonal allergies		Seizure disorder, epilepsy	
Depression		Heart disease		Thyroid condition	

Total: _____

Practitioner Notes: _____

_____

_____

_____

_____

_____

I _____ , hereby grant permission to receive a professional and complete physical examination and consultation, including urinalysis and evaluation.

_____ _____

Signature **Date**