**Confidential Health History/Intake Form**

Please type or write or print clearly

PERSONAL INFORMATION

|  |  |
| --- | --- |
| First Name: |  |

|  |  |
| --- | --- |
| Last Name: |  |

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| Email: |  | How often do you check email? |  |

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| Age: |  | Height: |  | Weight: \_\_\_\_\_\_\_\_ | Place of Birth: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Current weight: |  | Weight six months ago: | |  | | One year ago: | |  |
| Would you like your weight to be different? | | |  | | If so, what? | |  | |

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| Relationship status: |  | Children? |  |

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| Occupation: |  | | Hours of work per week: |  |
| Please list your main health concerns: | |  | | |
| When was the last time you felt really vibrant and well? | | | | |

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| Other current major life concerns? |  |

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| If you could wave a magic wand and change 2 things about your life right now, what exactly would they be? |  |

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| Any serious illness, hospitalization, injuries, and surgeries, either now or in your past? | | | |  | | |
| How is the health of your mother? If deceased, relay illnesses. | | |  | | | |
| How is the health of your father?  If deceased, relay illnesses. | |  | | | | |
| What is your ancestry? |  | | | | What blood type are you? |  |

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| Do you sleep well? | |  | How many hours? |  | Do you wake up at night? |  |
| Why? |  | | | | | |

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| Any ongoing sources of inflammation  (e.g. eczema or other skin irritation, chronic post nasal drip, congestion, headaches, achy muscles/joints, swelling, pain, stiffness)? |  |

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| **This section for women only** | | | | | | | | | |
| Are your periods regular? | | |  | How many days is your flow? | | |  | How frequent? |  |
| Painful or symptomatic? | |  | | Please explain: | |  | | | |
| Birth control history: |  | | | | | | | | |
| Vaginal infections, reproductive concerns? | | | | |  | | | | |

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| Do you struggle with Constipation, Diarrhea, Gas, Distension, Belching, or Bloating? Which? |  | Explain in detail: |  |

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| Please list ALL supplements or medications you take (prescription or over-the-counter) and frequency? |
|  |
| Have you ever taken antibiotics more than a short course or two as a child? If so, when/how often? For what? And for how long? |
| Any remarkable exposure to toxins (e.g. current or childhood home, nearby industrial community, job, hobbies, travel, pesticides, heavy metals)? |
| What is the general status of your dental health/care? |
| Any troubling dental work or history of dental/oral infections? Dentures? Root canals? |
| How many silver/mercury fillings do you have? Other major dental work/issues beyond basic cleanings? |

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| On a scale of 1 to 10, how would you rate your general energy level (1=lowest)? |
| To what do you attribute this energy level? |

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| Any healers, helpers, pets or therapies with which you are involved? Please list: |
| What are your primary hobbies? |
| What role do sports and exercise play in your life? |
| What do you do to relax? How often? |

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| What was your general health and well-being as a child? | | | | | | | | |
| What foods did you eat often as a child? | | | | | | | | |
| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
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| What’s your food like these days? | | | | | | | |  | |
| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | | Liquids |
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| Do you have any known food allergies or sensitivities? |  |

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| What percentage of your food is home-cooked? | |  | What percentage is not? |  |
| Where do you get the rest from? |  | | | |

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| If you have a general philosophy, mindset or approach you use when choosing foods, please describe it briefly. |  |

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| Do you crave sugar, carbs, alcohol, coffee, cigarettes, other foods, or have any addictions? |
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| Anything else you would like to share? |

Continue on to next page: Symptom Check List

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**Symptom Questionnaire**

**Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two years.** If multiple choices are given, please specify what applies in the comment column.

* Leave the score **blank** if you **Never** have the symptom.
* Use a **1** if you **Occasionally** have it and the effect is **Mild**.
* Use a **2** if you **Occasionally** have it and the effect is **Severe.**
* Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
* Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | **Symptom** | **Score** | **Comments or Details, if appl.** |  |
| **HEAD** | Headache |  |  | | |
| Faintness |  |  | | |
| Dizziness |  |  | | |
| Insomnia |  |  | | |
| **NOSE** | Stuffy nose |  |  | | |
| Sinus problems |  |  | | |
| Hay fever |  |  | | |
| Sneezing attacks |  |  | | |
| Excessive mucus formation |  |  | | |
| **MOUTH** | Chronic coughing |  |  | | |
| Gagging or frequent need to clear throat |  |  | | |
| Sore throat, hoarseness, or loss of voice |  |  | | |
| Swollen or discolored tongue, gums, or lips |  |  | | |
| Chronic tooth or gum pain or jaw pain. Which? |  |  | | |
| Canker sores |  |  | | |
| **SKIN** | Acne |  |  | | |
| Hives or other allergic breakout |  |  | | |
| Rash or persistently dry skin |  |  | | |
| Hair loss |  |  | | |
| Flushing or hot flashes |  |  | | |
| Frequently feel cold |  |  | | |
| Excessive sweating |  |  | | |
| Part of body frequently feeling numb. Which? |  |  | | |
| **HEART** | Irregular or skipped heartbeat |  |  | | |
| Rapid or pounding heartbeat |  |  | | |
| Chest pain |  |  | | |
| **LUNGS** | Chest congestion |  |  | | |
| Asthma, bronchitis |  |  | | |
| Shortness of breath |  |  | | |
| Difficulty breathing |  |  | | |
| **DIGESTION** | Nausea or vomiting |  |  | | |
| Diarrhea |  |  | | |
| Constipation |  |  | | |
| Bloated feeling |  |  | | |
| Belching, burping |  |  | | |
| Passing gas, flatulence |  |  | | |
| Heartburn |  |  | | |
| Intestinal or Stomach pain. Which? |  |  | | |
| Other pain in GI tract? Where? |  |  | | |

**(Page 2)**

**Please use this scale to rate the frequency and severity of symptoms you have experienced over the past two years.** If multiple choices are given, please specify what applies in the comment column.

* Leave the score **blank** if you **Never** have the symptom.
* Use a **1** if you **Occasionally** have it and the effect is **Mild**.
* Use a **2** if you **Occasionally** have it and the effect is **Severe.**
* Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
* Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | **Symptom** | **Score** | **Comments or Details, if appl.** | |
| **JOINTS AND MUSCLES** | Pain or aches in joints |  |  |
| Arthritis |  |  |
| Stiffness or limitation of movement |  |  |
| Pain or aches in muscles |  |  |
| Tremor or restless leg |  |  |
| Feeling of weakness or tiredness |  |  |
| **WEIGHT** | Binge eating/drinking |  |  |
| Craving certain foods |  |  |
| Excessive weight |  |  |
| Compulsive eating |  |  |
| Water retention |  |  |
| Underweight |  |  |
| **ENERGY** | Fatigue, sluggishness |  |  |
| Apathy, lethargy |  |  |
| Hyperactivity |  |  |
| Restlessness |  |  |
| **MIND** | Poor memory |  |  |
| Confusion, poor comprehension |  |  |
| Poor concentration or focus |  |  |
| Poor physical coordination |  |  |
| Difficulty in making decisions |  |  |
| Stuttering or stammering |  |  |
| Learning disabilities |  |  |
| **MOOD** | Mood swings |  |  |
| Anxiety, fear, nervousness |  |  |
| Anger, irritability, aggressiveness |  |  |
| Depression |  |  |
| Other mood challenges? |  |  |
| **OTHER** | Frequent illness |  |  |
| Frequent or urgent urination |  |  |
| Inability to urinate or low urine flow |  |  |
| Low libido or other sexual dysfunction |  |  |
| Genital itch or discharge |  |  |
| Women: Breast fibroids |  |  |
| Women: Painful or tender breasts |  |  |
| Women: Uterine fibroids |  |  |
| Other |  |  |
| Other |  |  |
| **Please tally your scores for this update here:** | |  | **Total Symptom Score** |
| Any further comments you wish to share? | | | |