Inside Health Solutions

Confidential Health History / Intake Form

Please complete and attach to Message or email directly to Susan@InsideHealthSolutions.com

Age: _____ Height: _____ Weight: _____ Place of birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

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

Relationship status: _____ Children? _____

Occupation: _____ Hours per week: _____

Please list your main health concerns: _____

When was the last time you felt vibrant and well? _____

Other current major life concerns: _____

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

_____

Any serious illness, hospitalization, injuries and surgeries, currently or in the 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? _____

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

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

_____

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: (use Key to indicate level)	Constipation	_____	Key
	Diarrhea	_____	0) not at all
	Gas	_____	1) during meals
	Disetnsion	_____	2) immediately after a meal
	Belching	_____	3) 1-2 hours after a meal
	Bloating	_____	4) 3+ hours after a meal

Additional information: _____

Please list all supplements or medications you take (prescription or over-the-counter) and frequency:

_____

Have you taken antibiotics more than a short course? If so, when/how often? For what? How long?

_____

Any obvious exposure to toxins (i.e. current/childhood home, near industry, job, hobby, travel, pesticides, etc.)

_____

What is the general status of you dental health care? _____

Any troubling dental work or history of dental / oral infections? Dentures? Root canals?

_____

How many silver or mercury fillings do you have? _____

Other major dental work/issues beyond basic cleanings? _____

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? _____

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

_____

What are your primary hobbies? _____

What role do sports and exercise plan in your life?

_____

What do you do to relax? _____ How often? _____

What was your general health as a child? _____

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Generally, what do you eat at meals?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____

Do you have any known food allergies or sensitivities ? _____

What percentage of your food is home-cooked? _____ What percentage is not? _____

Where do you get the rest from? _____

If you have a general philosophy, mindset or approach you use when choosing food, please briefly describe it:

_____

_____

Do you crave sugar, carbs, alcohol, coffee, cigarettes, other foods or have any addictions?

_____

_____

What are you goals for your health? _____

What is the #1 concern you would like help with? _____

What is your timeframe for change? _____

Anything else you would like to share?

_____

_____

_____

_____

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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** of 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
HEAD	Headache		
	Faintness		
	Dizziness		
NOSE	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
MOUTH	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore thoat, horseness 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		
	Parot of body frequently feel 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?		

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Category	Symptom	Score	Comments or Details
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; which ones?		
	Excessive weight gain		
	Excessive weight loss		
	Compulsive eating		
	Water retention		
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 uring flow		
	Low libido or other sexual dysfunction		
	Genital itch or discharge		
	Women: Breast fibroids		
	Women: Painful or tender breasts		
	Women: Uterine fibrosis		
	Other		
	Other		