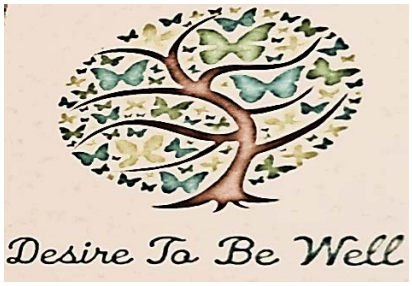

HEALTH HISTORY / DISCOVERY FORM

PERSONAL INFORMATION

Name: _____

Address: _____

Phone: _____

Email: _____

Age: _____ Height: _____ Birthdate: _____

Current Weight: _____ Weight Six Months Ago: _____ One Year Ago: _____

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

SOCIAL INFORMATION

Relationship Status: _____

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 illness/hospitalizations/injuries? _____

_____

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? _____

_____

_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

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?

_____

_____

_____

_____

SYMPTOM QUESTIONNAIRE

Please use this scale to rate the frequency and severity of symptoms you have experienced **over the past two weeks.**
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 or voice		
	Swollen or discolored tongue, gums, or lips		
	Tooth ache or gum pain or new dental work		
	Canker sores		
SKIN	Acne		
	Hives ot 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		
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		
	Intestinl or Stomach pain. Which?		
	Other pain in GI tract? Where?		

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		
	Temore 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, aggressvieness		
	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 fiboids		
	Women: Painful or tender breasts		
	Women: Uterine/Ovarian fibroids		
	Other		
Please tally your scores here:			**Total Symptom Score**
Any further comments you wish to share?			