Confidential Health History

Name

Full Address

Email Address

How often do you check your email?

Telephones

Work | Home | Cell

Age | Height | Date of Birth | Place of Birth

Current Weight | Weight six months ago | One year ago

Would you like your weigh to be different | Of so, what?

Occupation | Hours per week

Please list major health concerns:

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

Other current major life concerns?

If you would wave a magic wand and change two things what would they be?

Any serious illness(s), hospitalizations, injuries, surgeries, and trauma either now or in your past?

How is the Health of your mother? (If deceased relay illness)

How is the health of your father? (if deceased relay illness)

What is your ancestry?

What is your blood type?

Do you sleep well?

How many hours?

Wake up at nigth?

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 is 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?

Do you struggle with Constipation, Diarrhea, Gas, Distension, Belching, or Bloating? Which?

Please explain in detail

Urinary health- Do you suffer from frequent urination, stones, irritable bladder

Please explain your symptoms

Perspiration - Any spontaneous sweating, night sweats etc. Please explain

Please list ALL supplements you take (prescription or over-the counter) and frequency?

Please list ALL medications you take (prescription or over-the counter) and frequency?

Energy - How would you describe your overall energy? Are there particular times of the day when you are most energetic and when are you least energetic? Please explain.

What is your favorite season?

What is your social life like? How often are you engaging in social situations? Do you consider yourself an extrovert or introvert and/or both? Please explain.

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?

What foods did you eat as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you have any 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 foods, please describe it briefly

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

Anything else you would like to share?

PAYMENTS AND REFUNDS

The patient understands that payment is to be paid at the day of service. Payment is accepted by a check, credit card, cash, or any other electronic method (PayPal, Venmo, ApplePay).

The patient will remain fully responsible for any unpaid balance(s) not reimbursed by his/her Medical Insurance.

DISCLAIMER OF HEALTH CARE RELATED SERVICES

I encourage the patient to continue to visit and to be treated by his/her healthcare professional, including, without limitation, a physician MD. The patient understands that I am not acting in the capacity of a western medicine doctor, licensed dietitian-nutritionist, therapist, or psychologist.