

Confidential Health History

Please write or print clearly

Name: _____

Address: _____

Email address: _____ How often do you check email? _____

Telephone – Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

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

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

Relationship status: _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns: _____

Other concerns and/or goals? _____

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries? _____

How is the health of your mother? _____

How is the health of your father?

What is your ancestry?

What blood type are you?

Do you sleep well?

How many hours?

Do you wake up at night?

Why?

Any pain, stiffness or swelling?

Constipation/Diarrhea/Gas? Please explain:

Allergies or sensitivities? Please explain:

Do you take any supplements or medications? Please list:

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

What role does sports and exercise play in your life?

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

What's your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

What percentage of your food is home cooked? _____

Do you cook? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

The most important thing I should change about my diet to improve my health is: _____

Anything else you want to share? _____
