

Confidential Health History

Please fill this Health History out as accurately as you can, in order for me to get to the route course of your health concern!

Name

Your answer

Full Address

Your answer

Email Address

Your answer

How often do you check your email?

⃝ Daily

⃝ Weekly

⃝ Monthly

Work Phone

Your answer

Home Phone

Your answer

Cell Phone

Your answer

Age

Your answer

Height

Your answer

Date of Birth

dd/mm/yyyy

Current Weight

Your answer

Weight 6 Months Ago

Your answer

Weight 1 Year Ago

Your answer

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

Your answer

Occupation

Your answer

Hours per Week

Your answer

Major Health Concerns

Your answer

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

Your answer

Other current major life concerns?

Your answer

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

Your answer

Any serious illness, hospitalization, injuries, and surgeries, either now or in your past?

Your answer

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

Your answer

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

Your answer

What is your ancestry?

Your answer

What is your blood type?

Your answer

Do you sleep well?

⃝ Yes

⃝ No

⃝ Other:

How many hours?

Your answer

How often do you wake up in the middle of the night?

⃝ Often

⃝ Sometimes

⃝ Rarely

⃝ Never

What do you think is the reason for your sleeping problems (if any)?

Your answer

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

Your answer

Do you struggle with any of the following?

⃝ Constipation

⃝ Diarrhea

⃝ Gas

⃝ Distension

⃝ Belching

⃝ Bloating

Please explain your answer to the previous question in detail.

Your answer

How often do you have bowel movements?

Your answer

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

Your answer

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?

Your answer

Any remarkable exposure to toxins (e.g. current or childhood home, nearby industrial community, job, hobbies, travel, pesticides, heavy metals)?

Your answer

What is the general status of your dental/health?

Your answer

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

Your answer

How many silver/mercury fillings do you have?

Your answer

Have you had any other major dental work/issues beyond basic cleanings?

Your answer

On a scale of 1 to 10, how would you rate your general energy level (1=lowest)?

1 2 3 4 5 6 7 8 9 10

⃝ ⃝ ⃝ ⃝ ⃝ ⃝ ⃝ ⃝ ⃝ ⃝

To what do you attribute this energy level?

Your answer

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

Your answer

What are your primary hobbies?

Your answer

What role do sports and exercise play in your life?

Your answer

What do you do to relax? How often?

Your answer

What was your general health and well-being as a child? And has your diet changed much since then? If yes, please give me an idea of what your diet was like then.

Your answer

What is your gender? \*

Male

Female

What is your diet? Vegetarian – Vegan – Etc…

Give me an idea of what your diet looks like…

Breakfast and Time:

Lunch and Time:

Dinner and Time:

Snacks and Times:

How much water do you drink and what times do you drink your water?

Do you drink any fizzy drinks? Yes ⃝ How many/day No ⃝

Please list all medications you are taking and when you started taking them.

Please also list any other medications you may have taken over the past five years but have stopped.