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HEALTH HISTORY

Name:			Blood type:
Address:			
Home Phone:		Work Phone: Cell phone:	
Birth date:	Age:	Children:	Marital Status:
Occupation:			
Who referred you?			
What are your reasons for seeking this consultation:			
If you have seen other health practitioners, please describe how they were or weren't helpful to you.			
What are your long-term goals from your consultation? When we finish, what would you like to be taking with you?			
ALLERGIES to medications (name of the drug and type of reaction):			
Other ALLERGIES or SENSITIVITIES (Food, pollens, animals, chemicals):			
Do you exercise regularly?	Type of exercise?		

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How often?	Length of session?	Do you sweat?
Do you do any stress reduction, relaxation or mind/body practices such as meditation, yoga, prayer, journal writing, etc.?		
If yes, what types?	How often?	Length of sessions?
Do you consider yourself to be under low, moderate, or high levels of stress? (Circle one)		
Sleep habits: Hours/night	Restless or restful?	What time do you retire?
Do you wake during the night?	Do you dream?	
What are your hobbies or life interests?		
PAST HISTORY		
Did your mother have any problems during her pregnancy with you (illness, stress, smoking, medications, alcohol)?		
Were you bottle or breast-fed?		
Was your home life: (circle one) loving, supportive, stressful, abusive, peaceful, loud, argumentative, educational, alcoholic, friendly, single parent, lonely? Add others or comments here:		
Circle any of the following childhood illnesses that you had: Colic, Eczema, Asthma, Polio, Allergies, Bronchitis, Pneumonia, Meningitis, Rheumatic fever, Recurrent colds, Ear infections, Thrush, German Measles, Bedwetting, Tonsillectomy, Persistent diaper rashes, Learning disabilities, Hyperactivity.		
Describe any other past medical problems as a child or adult (please give dates):		

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HAVE YOU EVER BEEN ON FREQUENT OR PROLONGED ANTIBIOTIC THERAPY such as Erythromycin, Penicillin, Tetracycline, Sulfa drugs, Flagyl, etc.?				
Have you ever traveled outside of the country?			Had travelers'diarrhea?	
Been treated for parasites?		Been tested for intestinal parasites?		
List major hospitalizations: Give dates, locations, reasons (diagnoses), length of hospital stays, any surgeries:				
Your height:	Current weight	Lowest adult weight:	Highest:	Desired:
HABITS: Please be specific with your answers regarding types and quantities where requested.				
Do you use cosmetics?	Perfumes?	Aftershaves?	Scented Soaps?	
DO YOU SMOKE?	How much per day?	For how long have you smoked?		
Did you ever smoke?	How much?	For how long?	When did you stop?	
ALCOHOL USE? Specify what type, how much, and how frequently.				
Do you drink to excess?	Did you ever drink a lot of alcohol?	When did you stop?		
DRUG USE (non-medicinal) specify type and frequency:				
CAFFEINE USE: How much of each of the following do you consume:				
Coffee?	Tea?			
Chocolate or cocoa?	Colas or other caffeine soft drinks?			

Non-prescribed medications (laxatives, aspirin, antihistamines, decongestants, stimulants, etc.)

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Prescribed medications (names and doses)

NUTRIENT SUPPLEMENTS: If you are taking vitamins, minerals, herbs or other supplements, please list them below:

DIET SURVEY: Please take the time to answer these questions specifically and **concisely.**
What do you normally eat or drink at and between meals?

Specify what foods and beverages you normally consume during a typical day:

Meal	***WEEKDAYS***	***WEEKENDS***
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		
Do you binge?	Use food for reward or escape?	
If so, what foods or beverages do you use, and how often?		

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What foods would be most difficult for you to give up?			
Do you have specific food cravings?	What foods?		
What work or scheduling considerations might create difficulties for you in trying to change your eating or any other health habits?			
Do you like to cook? What percentage of your food is home cooked?			
List any known food sensitivities:			
How often do you have a bowel movement?			
Consistency of stool (please circle):	Compact/Hard	Medium/Formed	Loose
Color of stool (please circle):	Very light	Medium	Very dark

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DIET SURVEY continued

Please check all of the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

"FREQUENT" = at least once per day; "OFTEN" = several times a week; "OCCASIONAL" = once a week or less
"SELDOM" = once or twice a month or less; "NEVER" = almost total avoidance.

Frequent	Often	Occasional	Seldom	Never	
					Alcoholic beverages
					Eat at restaurants
					Eat at fast food restaurants
					Pastries, cookies, candies, ice cream, other sweets
					Add sugar to coffee, tea, cereals or other foods
					Colas or other soft drinks
					Instant breakfasts, pop tarts, doughnuts, muffins
					Cold breakfast cereals
					Caffeine drinks (coffee, tea, cola, chocolate)
					Deep fried foods
					Margarine of <u>any</u> type
					Whole grain hot cereals (oatmeal, wheatena, etc.)
					Meat (beef or veal, pork or ham, lamb, liver)
					Chicken or turkey (circle: regular or free-range)
					Fresh fish
					Processed meat (bologna, turkey roll, sausages, etc.)
					Fresh raw fruit
					Fresh vegetables, raw or cooked
					Salads
					Whole grains or whole grain breads
					White bread or white flour products
					Beans and legumes (lentil, kidney, chickpea, etc.)
					Yogurt (circle: whole or lowfat; plain or flavored)
					Milk (circle: whole, lowfat or skimmed)
					Cheese
					Eggs (circle: regular or free range)
					Salt
					Herbs, fresh and dried, or spices
					Drink adequate water (circle: tap, filtered, bottled)
					Eat excessively if bored or depressed
					Swallow food before chewing well
					Hurried or rushed meals
					Stuff yourself
					Read and understand food labels

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					Sneak or hide food
					Adequate fiber or roughage in diet
					Artificial sweeteners (saccharin, Nutrasweet, etc.)
					Shop at health food stores