

General Health History

NAME _____ DATE _____
PHONE # _____
ADDRESS _____
EMAIL ADDRESS: _____
EMERGENCY CONTACT _____
RELATIONSHIP & PHONE NUMBER _____
BIRTHDATE _____ SEX _____ HEIGHT _____ WEIGHT _____
OCCUPATION _____
DO YOU LIKE YOUR JOB? _____
ARE YOU IN A RELATIONSHIP? _____
CHILDREN? AGES? _____

WHAT IS YOUR MAIN CONCERN THAT BROUGHT YOU HERE TODAY?

Vegetarian? NO ___ YES ___ DESCRIBE YOUR TYPICAL DAILY FOOD INTAKE:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____

PLEASE DESCRIBE YOUR TYPICAL DAILY FLUID INTAKE:

Water _____ Alcohol _____
Coffee/Tea _____ Soda _____
Juice _____ Other _____

WHAT TYPE OF WATER DO YOU DRINK? _____

HOW MUCH SLEEP DO YOU GET ON THE AVERAGE? _____ IS IT SOUND? _____

DO YOU WAKE TO VOID ? _____ DO YOU HAVE URINARY URGENCY? _____

DESCRIBE YOUR NORMAL BOWEL HABIT—frequency & consistency (i.e. formed or loose stool)

DESCRIBE YOUR ENERGY LEVEL: _____

DESCRIBE YOUR DAILY SCHEDULE OR ACTIVITIES: _____

DO YOU FEEL STRESSED? _____

WHAT DO YOU DO WHEN YOU FEEL STRESSED? _____

DO YOU CURRENTLY SEE A MEDICAL DOCTOR FOR ANY REASON? _____

WAS AN ILLNESS DIAGNOSED? _____

DO YOU HAVE A PACEMAKER? _____ DEFIBRILLATOR? _____
ARE YOU PREGNANT? _____

PLEASE LIST ANY SUPPLEMENTS YOU ARE NOW TAKING

WHAT TYPES OF EXERCISE OR PHYSICAL MOVEMENT DO YOU DO?

DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

- | | | |
|--|---|---|
| <input type="checkbox"/> ALLERGIES* | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> JOINT ACHES |
| <input type="checkbox"/> LEG CRAMPS | <input type="checkbox"/> DIZZY SPELLS | <input type="checkbox"/> FLUID RETENTION |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> SKIN PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> NERVOUS TENSION | <input type="checkbox"/> MOOD SWINGS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART PROBLEMS |
| <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> HIGH CHOLESTEROL |
| <input type="checkbox"/> PMS/ MENOPAUSE CONCERNS | <input type="checkbox"/> MENSTRUAL CRAMPS | |

*ALLERGY TO: _____

DO YOU HAVE FOOD CRAVINGS SUCH AS CHOCOLATE, BREADS, ALCOHOL OR SWEETS?

IS THERE ANYTHING YOU HAVEN'T TOLD ME THAT YOU THINK I SHOULD KNOW?

HOW DID YOU FIND OUT ABOUT US? _____

