

Current And Past Health History:

Name: _____

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Please check all applicable past or present and enter the date of onset:

AIDS/HIV		High Blood Pressure	
Alcoholism		Kidney Disease	
Allergies		Liver Disease	
Anemia		Migraine Headaches	
Anorexia/Bulemia		Miscarriage	
Appendicitis		Mononucleosis	
Arthritis (OA,RA,Other)		Multiple Sclerosis	
Asthma		Osteoporosis	
Bleeding Disorders		Pacemaker	
Breast Lump		Parkinson's Disease	
Bronchitis/Pneumonia		Polio	
Cancer		Prostate Problems	
Cataracts		Prosthesis	
Chronic Fatigue		Psychiatric Care	
Depression / Anxiety		Recreational Drugs	
Diabetes		Rheumatic Fever	
Emphysema		Scarlet Fever	
Epilepsy (Seizures)		Stroke	
Fractures		Suicide Attempt	
Glaucoma		Thyroid Problems	
Goiter		Tropical Diseases	
Gonorrhea		Tuberculosis	
Gout		Tumors, Growths	
Heart Disease		Ulcers	
Hepatitis A_B_C_Oth_		Vaccine Reactions	
Hernia		Vaginal Infections	
Herniated Disc		Venereal Disease	
Herpes		Whooping Cough	
High Cholesterol		Other	

Date: _____

Nutritional Information

Name: _____

Surgeries & Hospitalization: Please list all surgeries & Hospitalizations, include the dates

Surgery/Hospitalization	Date	Why	Outcome

Traumatic Injuries and/or Major Illnesses: Please include date it happened.

Trauma or Illness	Date	Outcome

Allergies: Please list all your allergies (Food, Drugs and any other Substances)

Allergen	Symptom	How Long Have You Had It?

Current(C) & Past(P) Medications: Please list all your medications and their purpose

Name (C or P)	Dosage	Why Are You Taking?	How Long	Outcome

Current Supplementation: Please all your vitamins and minerals and their purpose

Name	Dosage	Why Are You Taking?	How Long	Outcome

Please Bring Any Diagnostic Tests (ie: Blood Tests, Scans, etc) With You.

Date: _____

Family Information

Name _____

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Please Tell Us About Your Family:

Parents:

Mother	Living	Dead	Date	Age	Why
Father	Living	Dead	Date	Age	Why

Siblings:

How Many Siblings Do You Have Sisters: _____ Brothers: _____

	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why
	Living	Dead	Date	Age	Why

Family History: Specify Which Member of Your Family (Parents / Siblings / Grandparents)

	When	Who
Abuse		Heart Disease
AIDS/HIV		Hepatitis
Alcoholism		Liver Disease
Allergies		Herpes
Arthritis		High Cholesterol
Asthma		High Blood Pressure
Bleeding Disorders		Kidney Disease
Cancer		Osteoporosis
Depression		Psychiatric Care
Diabetes		Recreational Drugs
Epilepsy (Seizures)		STD
Glaucoma		Suicide Attempt
Goiter		Other

Date: _____

Nutritional Information

Name: _____

What Are Your Favorite Foods and how often you eat them?

What Foods If Any Do You Crave:

What Foods Do You Avoid and Why:

How Many Meals Do You Eat: Week Days _____ Weekends _____

Do You Eat: Between Meals _____ Bedtime _____ During The Night _____

What Do You Snack On & How Often:

Where Is Your Daily Food Prepared: Home _____ % Restaurant _____ % Fast Food _____ % Other _____ %

If Other Explain:

How Is Your Food Prepared At Home (ie: Bake, Boil, Broil, Fry, etc):

What Type Of Ingredients Do You Use (ie: Fresh, Frozen, Canned, Prepared, etc):

What Do You Eat When You Are Out:

What Do You Drink With Your Meals:

What Do You Drink During The Day: (Include How Much)

What Kind Of Water Do You Cook In: Tap _____ Spring _____ Filtered _____ Distilled _____

What Kind Of Water Do You Drink: Tap _____ Spring _____ Filtered _____ Distilled _____

Do You Use Artificial Sweeteners: Yes _____ No _____ What Kind: _____

Date: _____

Nutritional Information

Name: _____

Are You Now or Have You Ever Been On Any Diets: Yes No

If Yes What Type Of Diet(s): _____

Low Carb: _____ High Protein: _____ Low Fat: _____

High Fiber: _____ Liquid (ie slimfast): _____ Low Salt: _____

Diabetic: _____ Low Cholesterol: _____ Vegetarian: _____

Other: _____

Food Pyramid (Specify What Version): _____ Other: _____

Weight Loss or Gain as a result: _____

How Is Your Appetite: Normal Excessive Diminished None Varies (Please Explain)

Have You Ever Fasted: Yes No How Long? _____

What Kind of Fast Did You Do? _____

Have You Ever Been on A Detoxification Program: How Long? _____

What Detox Program Did You Follow? _____

Height: _____ Current Weight: _____

Previous Height: _____ Height Loss/Gained in Last Year _____

Most You've Weighed: _____ Weight Loss/Gained in Last 6 Months: _____

What's Your Goal: Gain Lose How Much? _____ Remain Unchanged _____

Do You Exercise? _____ How Often? _____

Type of Exercise: _____

Any Problems While Exercising: _____

Little or No Sweating During Exercise Profuse Sweating During Exercise

Patient or Patient Representative Signature Date