Confidential Health History Form

Name: _____ Email Address: _____

Address:_____

Contact Phone # Home: _____Cell:_____ Work: _____

Height: _____ Age: _____ Date of birth: _____ Place of birth: _____

Current Weight: _____Past weight: _____ Desirableweight: _____

Current relationship status: Single: _____ Married: _____ Divorced: _____ other: _____

Children:_____ Pets: _____

Occupation:_____ Average hours worked per week:_____

Past medical history: _____

_____

_____

_____

Family history

Please list the medical history of your parents.

Mother:_____

_____

Father:_____

_____

What is your heritage?_____ Blood type? _____

How well do you sleep?_____ Average hours per night?_____

Additional Comments: _____

_____

_____

Drug sensitivities or allergies (describe)?_____

_____

Are you experiencing any digestion problems such asconstipation, gas, diarrhea or IBS? _____

_____

_____

Any swelling, stiffness or pain?_____

Do you take any medications or supplements?___Please list:_____

_____

_____

Are you involved with any other healers in supporting your health besides a medical doctor? _____

Please list:_____

_____

_____

Do you exercise or participate in any sport activity? _____

_____

_____

Your typical diet growing up as a child!

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Your typical diet today!

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What percentage of your food is cooked at home?_____Do you like to cook? _____

What constitutes the rest of your diet?_____

Do you have any addictions such as: drugs, alcohol, sugar, cigarettes, coffee, etc.? _____

_____

_____

Please list your health concerns and goals: _____

_____

_____

_____

_____

What would you like change in your life to improve your health? _____

_____

_____

_____