CONTACT INFORMATION

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Best way to contact you: _____

PERSONAL INFORMATION

Date of birth: _____(MM/DD/YYYY) Place of birth: _____

Age: _____ Height: _____ Weight: _____

Highest weight ever: _____ Year: _____ Lowest weight ever (as an adult): _____ Year: _____

Occupation: _____ How long: _____

On a scale from 1 (hate) to 10 (love), how do you like your work? _____

Previous occupation: _____

Education (highest level attained): _____

Relationship status: _____ Number of times: _____ Married _____ Divorced _____ Widowed

Are you pregnant or planning to get pregnant? _____Yes _____ No

Number of children? _____ Breastfeeding? _____Yes _____ No

Recent Surgery? _____ Trauma? _____ Infection? _____

Where and when have you lived or traveled outside the U.S. and Canada: _____

_____

REASONS FOR COMING TO SEE ME

Please list your major health concerns in order of importance: Duration?

1. _____
2. _____
3. _____
4. _____
5. _____

ACTIVITY LEVEL (choose only one)	**Type of activity?**	**Duration?**
Sedentary (little or no exercise, desk job or bed ridden)		
Light activity (exercise 1-3 days per week)		
Moderate activity (exercise 3-5 days per week)		
Very active (exercise 6-7 days per week)		
Extremely active (hard daily exercise or physically demanding job)		

Are you satisfied with your energy levels? _____ Yes _____ Sometimes _____ No
On a scale of 1 (I feel sick) to 10 (I feel fantastic), where would you rate your sense of well being? _____

DIET

How many times per week do you eat at restaurants? _____

How many times per week do you cook or prepare food at home? _____

Do you have any special dietary restrictions or preferences? Are there any foods that you avoid and why?

_____

_____

_____

Have you ever followed a specific diet? If so, which one(s), for how long, and why? _____

_____

_____

_____

_____

What foods do you crave, if anything? _____

_____

_____

What substances (food or environmental), if any, are you allergic or sensitive to? _____

_____

_____

GENERAL HEALTH QUESTIONS

Do you have regular bowel movements? _____ Yes _____ No How many per day? _____ Per week? _____

Is it ever difficult to move your bowels? _____ Yes _____ No

Typical bedtime _____ Typical hours of sleep per night _____

On a scale from 1 (low) to 10 (high), how stressful is your:

Work _____

Health status _____

Social/family situation _____

MISCELLANEOUS ITEMS

Name and phone number of regular physician: _____

Date of last appointment with physician: _____ Reason for that appointment: _____

_____

Other health care providers? _____

FAMILY HISTORY

Circle illnesses which have occurred in any of your blood relatives:

Diabetes	Cancer	Bleeding tendency	Kidney Disease
Stroke	High blood pressure	Nervous illness	Allergy/Asthma
Arthritis	Obesity	Depression	Headaches/Migraines
Osteoporosis	Liver Disease	Heart Disease	Respiratory disease
Lyme Disease	Addiction	Metabolic Syndrome/Insulin Resistance	
Eczema/psoriasis	Digestive issues	Thyroid disease	

Relationship	**Alive/Deceased**	**Present health or cause of death**
Father	_____	_____
Mother	_____	_____
Brother	_____	_____
Sister	_____	_____
Children/ages	_____	_____
	_____	_____

Medications currently or previously used (including prescriptions and over the counter medications):

Name & Reason for Taking	Dosage/Frequency	Duration (years, months, weeks)?

Supplements currently used (vitamins/herbs):

Type/Brand & Reason for Taking	Dosage/Frequency	Duration (years, months, weeks)?

Please list major events in the last ten years of your life and the dates they occurred (included births, deaths, marriages, divorce, accidents, moves, job changes, miscarriages, illness and anything else you feel greatly impacted your life).

Date: _____

Event: _____

_____

_____

_____

Date: _____

Event: _____

_____

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Date: _____

Event: _____

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Date: _____

Event: _____

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