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Brief Health Information Form

A. Identification

Client's name: ____________________________________ DOB: ______________ Date: __________

B. History

1. Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents, and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies in section E.) Use another sheet If necessary.

Age	Illness/diagnosis	Treatment received	Treated by	Result

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List all medications, drugs, or other substances you take or have taken in the last year - prescribed, over-the-counter vitamins, herbs, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

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4. Have you done any kinds of work where you were exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

C. Medical Caregivers

1. Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

2. Other physicians or alternative practitioners treating you at present or in last 5 years:

Name	Specialty	Address	Phone #	Date of last visit

D. Health Habits

1. Do you eat three meals a day? ❑No ❑Yes Do you skip meals? ❑No ❑Yes

Which ones? ____

2. Do you crave sugars? ❑No ❑Yes What do you eat? ___________________________________

3. Do you eat out? ❑No ❑Yes How often?____

Where are your favorite places to eat? ____

Do you prepare meals? ❑No ❑Yes What do you like to prepare? __________________________

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4. What kinds of physical exercise do you get? and how often?___________________________________

____

5. How much coffee, cola, tea or other sources of caffeine do you consume each day? Which?

____

Do you use coffee to wake up? ❑No ❑Yes

6. Do you try to restrict your eating in any way? ❑No ❑Yes

How?

____

Why?

____

7. Do you have any problems getting enough sleep? ❑No ❑Yes

If yes, what problems? (i.e. Can't fall asleep, Can't stay asleep, Wake up early, Other)

____

____

8. Do you have digestive issues, such as gas, bloating, acid reflux, indigestion? ❑No ❑Yes

If yes, please describe ____

____

9. Do you have food allergies? ____

Have you had food sensitivity testing? ❑No ❑Yes

Are you gluten free, sugar free, corn free, dairy free? ____

10. Have you been diagnosed with an autoimmune disease? (i.e. Fibromyalgia, Multiple Sclerosis,

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Hashimoto's Thyroiditis, Grave's Disease, Rheumatoid Arthritis, Diabetes, Celiac, Non-Gluten Celiac Sensitivity, Other)

____

11. When was the last time you had blood labs done by your doctor? __________________________

Why?

____

12. How long have you been suffering with the above conditions? _____________________________

____

13. What are the major stressors in your life? ____

____

E. For Women Only

At what age did you start to menstruate (get your period)? _________

Menstrual period experiences:

a. How regular are they?

____

b. How long do they last?

____

c. How much pain do you have?

____

d. How heavy are your periods?

____

e. Other experiences during periods?

____

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Please list all of your pregnancies:

	Your age	Miscarriage	Abortion	Child born	Problems?
1.					
2.					
3.					
4.					
5.					
6.					

Menopause:

If your menopause has started, at what age did it start? __________________

What signs or symptoms have you had? ____

____

Have you had female hormones tests recently? ____

F. Other

Do you use tobacco? ❑No ❑Yes

If yes, how many cigarettes/cigars/other do you use each day? _________

Do you use marijuana? ❑No ❑Yes If yes, how frequently? ____________Why? _________________

Have you ever injected drugs? ❑Yes ❑No Ever shared needles? ❑Yes ❑No

Have you had HIV testing in the last 6 months? ❑Yes ❑No. If yes, results: ____________________

Do you use drugs recreationally ❑ No ❑Yes If yes, which ones? ______________________________

Are there any other medical or physical problems you are concerned about?

____

____

____