IntegrativeHealth SOLUTIONS

HEALTH HISTORY

NAME: _____DATE: _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____CELL PHONE:_____

EMAIL:_____

DATE OF BIRTH: _____WEIGHT: _____ HEIGHT:_____

Reason for consultation and/or goals: _____

_____

Do you smoke?_____ Drink alcohol? _____ How much/when?_____

Do you have food allergies, restrictions, or sensitivities, environmental allergies?

_____

_____

Describe your daily energy levels:

_____

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while? _____

Do you crave certain foods? _____ If so, which foods and when?_____

Do you crave any of the following? ❒ Sugar ❒ Meat Fat ❒ Chocolate ❒ Fish ❒ Alcohol ❒ Desserts ❒ Milk ❒ Bread ❒ Fried foods ❒ Other _____

Do you take any nutritional supplements or vitamins? _____ If so, which ones? (be specific. Attach sheets if necessary)

_____

_____

Which prescription and over the counter medications do you take regularly?

_____

_____

Do you have any medication allergies? _____

Which oils do you use/consume?

❒ Butter ❒ Peanut Oil ❒ Canola ❒ Margarine ❒ Corn Oil ❒ Sun/Safflower ❒ Olive Oil

❒ Crisco ❒ Mayonnaise ❒ Coconut Oil ❒ Vegetable Oil ❒ Flaxseed Oil ❒ Soybean Oil ❒ Other_____

How is your dental health? _____

How many bowel movements do you have a day? _____

Rank your skin without lotion: ❒ Very Dry ❒ Dry ❒ Normal ❒ Oily ❒ Combination

Please check off any of the following that pertain to you (past or present–please mark present conditions with a P next to it:

❒ Acne ❒ Difficulty losing weight ❒ Kidney stones ❒ Addiction (alcohol, drugs) ❒ Difficulty gaining weight ❒ Liver problems ❒ Anemia ❒ Emotional problems (instability or sensitivity) ❒ Loose stools ❒ Anorexia ❒ Emphysema ❒ Memory loss or confusion ❒ Anxiety or nervousness ❒ Fainting ❒ Nails, poor growth ❒ Arthritis (Rheumatoid or Osteo) ❒ Gallbladder problems ❒ Panic attacks ❒ Bladder infections (Cystitis) ❒ Gout ❒ Parasites ❒ Bloating, gas or indigestion ❒ Hair loss or poor hair growth ❒ Pregnant or nursing mother ❒ Blood Sugar problems ❒ Headaches ❒ Respiratory problems ❒ Bronchitis ❒ Heart disease or problems ❒ Ringing in ears ❒ Cancer ❒ Heartburn ❒ Seizures ❒ Colds or flu (frequent) ❒ Hemorrhoids ❒ Severe mood swings ❒ Cold Sores ❒ Herpes simplex or type II ❒ Skin conditions ❒ Chronic fatigue ❒ High blood pressure ❒ Stroke ❒ Constipation ❒ High cholesterol ❒ Suicidal tendencies ❒ Dandruff ❒ Thyroid condition ❒ Depression ❒ Hot flashes ❒ Ulcer ❒ Diabetes I (insulin dependent) ❒ Diabetes II or Pre Diabetes ❒ Hypoglycemia ❒ Yeast infections ❒Insomnia ❒ Diarrhea ❒ Intestinal problems

Please check all that pertain:

Women:
❒ PMS ❒ Frequent urination ❒ Irregular periods ❒ Painful periods ❒ Loss of periods ❒ Loss of libido ❒ Birth control pills ❒ Menopause ❒ Painful intercourse ❒ Children ❒ Hysterectomy

Men:
❒ Difficulty urinating ❒ Difficulty with erection ❒ Loss of libido ❒ Prostate enlargement ❒ Loss of muscle ❒ Afternoon fatigue ❒ Lack of motivation ❒ Decreased Performance ❒ Brain Fog

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____

_____

_____

Personal weight loss history: How many diets have you been on? _____ Which ones?

_____

What were your results?

_____

Do you exercise? _____ If so, what kind? _____How often: Since when?_____

Please rate the Following:

Daily energy level: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Energy level after exercise: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Daily stress level: ❒ Very High ❒ High ❒ Moderate ❒ Low ❒ None

Do you have a support system of family and friends? _____

General enjoyment of life: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

How many hours do you sleep? _____ Do you sleep throughout the night?_____ Do you wake up without an alarm? ___Do you wake up feeling rested? ___ Do you fall asleep within 15 minutes?____

Please describe any health concerns you think are important:

_____

_____

_____

Signed: _____ Date:_____