CONFIDENTIAL HEALTH HISTORY

Name:			
Address:			
Email address:		How often do you check email?	
Telephone – Work / Home / Cell:			
Age:	Height:	Date of Birth:	Place of Birth:
Current weight:	Weight six months ago:	Weight one year ago:	Weight two years ago:
Would you like your weight to be different?		If so, what?	
Relationship status:			
Children:		Pets:	
Occupation:		Hours of work/school per week:	
Please list your main health concerns:			
Allergies or sensitivities? Please explain:			
Do you take any supplements or medications? Please list ALL:			
Other concerns and/or goals?			

At what point in your life did you feel best?		
Any serious illnesses/hospitalizations/injuries?		
How is/was the health of your mother?		
How is/was the health of your father?		
What is your ancestry?		
Do you sleep well?	How many hours?	Do you wake up at night? If so, why?
Any pain, stiffness or swelling?		
Constipation/Diarrhea/Gas? Please explain:		
Any healers, helpers or therapies with which you are involved? Please list:		
What role does sports and exercise play in your life?		
Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?		
What percentage of your food is home cooked?	Do you cook?	
Where do you get the rest from?		
Do you crave sugar, coffee, cigarettes, or have any major addictions?		
The most important thing I should change about my diet to improve my health is:		
Anything else you want to share?		

FOR WOMEN ONLY		
Are your periods regular?	How many days is your flow?	How Frequent/Painful?
Reached or approaching menopause?	Birth control history:	Do you experience yeast or urinary tract infections?