*Please fill out this entire form to the best of your ability. If you do not know the answer to something, leave it blank. If you have any questions about how to answer something, ask during our meeting. This form is not being used to diagnose any medical condition or to prescribe a controlled substance. The purpose of this form is not to indicate a medical opinion, but is for educational purposes only.*

|  |  |
| --- | --- |
| **Date** | Click here to enter a date. |
| **First and Last Name** | Click here to enter text. |
| **Cultural Heritage** | Click here to enter text. |
| **Street address, City, State, Zip Code** | Click here to enter text. |
| **Email Address** | Click here to enter text. |
| **Phone** | Click here to enter text. |
| **Occupation** | Click here to enter text. |
| **Emergency Contact/Phone** | Click here to enter text. |
| **Referred by** | Click here to enter text. |

**Please list info for all Medical Providers you are working with or whom you have active prescriptions for (if there are more than 10, please attach list of additional):**

Medical Provider #1

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #2

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #3

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #4

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #5

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #6

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #7

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #8

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #9

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

Medical Provider #10

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Type of provider (e.g. psychiatrist, chiropractor, endocrinologist, massage therapist, etc.) | Click here to enter text. |
| Phone # | Click here to enter text. |
| Date of last visit | Click here to enter text. |

**What is the reason for your visit?** Click here to enter text.

**List your top 5 health concerns in order of importance:**

1. Click here to enter text.

2. Click here to enter text.

3. Click here to enter text.

4. Click here to enter text.

5. Click here to enter text.

**How would you describe your health?** Click here to enter text.

**Briefly state your relationship to the following, including any issues, concerns and/or successes:**

Eating: Click here to enter text.

Sleeping: Click here to enter text.

Social Life: Click here to enter text.

Creative Projects/Hobbies: Click here to enter text.

Exercise/Activity: Click here to enter text.

Spiritual Practices: Click here to enter text.

Family: Click here to enter text.

Career: Click here to enter text.

Cooking: Click here to enter text.

**Do you cook?** [ ] Yes [ ] No If no, who does? Click here to enter text.

**Do you grocery shop?** [ ] Yes [ ] No If no, who does? Click here to enter text.

**Do you read food labels?** [ ] Yes [ ] No If yes, what do you look for? Click here to enter text.

**Do you currently follow a special diet or nutritional program?** [ ] Yes [ ] No If yes, check all that apply:

[ ] Low Fat [ ] Low Carb [ ] High Protein [ ] Low Sodium [ ] Diabetic/Low sugars

[ ] Vegetarian [ ] Vegan [ ] Pesca-vegetarian [ ] Paleo/Primal [ ] Renal

[ ] Candida [ ] Weight Loss [ ] Macrobiotic [ ] Raw [ ] Gluten Free

[ ] Other: Click here to enter text.

**Do you have any food allergies/intolerances/Sensitivites?** [ ] Yes [ ] No If yes, list foods: Click here to enter text.

Any foods cause indigestion symptoms? [ ] Yes [ ] No If yes, list foods: Click here to enter text.

Any foods you avoid? [ ] Yes [ ] No List foods and why you avoid them: Click here to enter text.

**Which foods, if any, do you feel you can’t live without?** Click here to enter text.

**How many alcohol containing beverages do you generally consume per week?** Click here to enter text.

**How many glasses of these do you generally consume daily?**

CoffeeChoose an item. Regular Soda Choose an item. Diet Soda Choose an item.

Fruit juice Choose an item. Water Choose an item. Black tea Choose an item.

Green Tea Choose an item. Herbal tea Choose an item. Energy Drinks Choose an item.

**Any immediate relatives diagnosed with Ulcerative Colitis, Crohn’s Disease, Celiac Disease, IBS, IBD?** [ ] Yes [ ] No

If yes, who? Click here to enter text.

**Height (feet and inches):**  Click here to enter text.

**If known, current weight** Click here to enter text. Desired weight, if different Click here to enter text.

How often do you weight yourself? Choose an item.

**Rate your stress level for each of these during the average week on scale of 0-10 with 0 being none and 10 being overwhelming:**

Work Choose an item. Family Choose an item. Social Choose an item.

Financial Choose an item. Health Choose an item. Other: Click here to enter text.: Choose an item.

Is stress reducing the quality of your life? [ ] Yes [ ] No

Do you have a stress relief technique? [ ] Yes [ ] No If yes, how do you relieve stress? Click here to enter text.

**Do you like the work you do?** [ ] Yes [ ] No

What are your passions in life? (e.g. If you could be doing anything right now and be paid for it, in your idealistic world what would that be?) Click here to enter text.

**Do you have trouble falling asleep?** [ ] Yes [ ] No

Do you have problems with insomnia? [ ] Yes [ ] No

Average hrs of sleep--workdays? Click here to enter text. Average sleep hrs on days off? Click here to enter text.

**Check all factors that apply to your current lifestyle and eating habits:**

[ ]  Fast eater [ ]  Slow eater [ ] Late night eater [ ] Eat while working

[ ] Eat in front of tv/computer [ ] Dislike “healthy” food [ ] Family dislikes “healthy” food

[ ] Time constraints [ ] Love to eat [ ] Travel frequently [ ] Plans meals/menus

[ ] Rely on “convenience” items [ ] You have special dietary needs/preferences

[ ] Your family has special dietary needs/preferences [ ] Eat more than 50% of meals away from home

[ ] You only eat because you have to [ ] Eat when bored [ ] Eat when sad, lonely or depressed

[ ] Eat when stressed [ ] Don’t eat when stressed [ ] Don’t like to cook

[ ] Love to cook [ ] Eat in the middle of the night [ ] Confused about nutrition advice

[ ] Crave sweets [ ] Have afternoon sugar cravings [ ] Choose “unhealthy” snacks

Have you ever smoked/chewed tobacco? [ ] Yes [ ] No For how long? Click here to enter text.

Do you currently smoke/chew tobacco? [ ] Yes [ ] No Amount per day Click here to enter text.

**List all medications, prescription and over the counter that you currently take: (if there are more than 15 please attach list of any additional)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Start Date (mo/yr)** | **Reason for Use** |
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**List all supplements, vitamins, herbs, etc. that you currently take: (if there are more than 15 please attach list of any additional)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Supplement & Brand** | **Dose** | **Frequency** | **Start Date (mo/yr)** | **Reason for Use** |
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Have any of your medications or supplements ever caused you any unusual side effects or problems? [ ] Yes [ ] No

If yes, which ones and what was the side effect? Click here to enter text.

Have you ever used NSAIDs—Non-steroidal anti-Inflammatory Drugs (e.g. Advil, Aleve, Motrin, Aspirin, Ibuprofen, etc.) on a regular basis? [ ] Yes [ ] No

Generally, how many NSAIDs pills do you take a week? Choose an item.

How many times per week, generally, do you currently take Acid Blocking Drugs (e.g. Tagamet, Zantac, Prilosec, Tums, etc.)? Choose an item.

Have you used steroids (prednisone, nsasal allergy inhalers, etc.) in the the past? [ ] Yes [ ] No

If yes, when? Click here to enter text. How much? Click here to enter text. How long? Click here to enter text.

Have you taken antibiotics more than 3x/in the last year? [ ] Yes [ ] No

Have you taken any long-term antibiotics? [ ] Yes [ ] No If yes, when? Click here to enter text.

For how long? Click here to enter text.

**List hospitalizations, include dental surgeries and serious injuries/broken bones (add additional sheet if necessary):**

|  |  |
| --- | --- |
| **Date** | **Reason** |
| Click here to enter text. | Click here to enter text. |
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**Blood Type:** [ ]  A [ ]  B [ ]  O [ ]  AB [ ]  Rh negative [ ]  Don’t Know

**Check any conditions you currently have:**

[ ]  Chicken Pox

[ ]  Seasonal Allergies

[ ]  Parasites/Giardia

[ ]  Eating disorder

[ ]  Hepatitis

[ ]  Hypothyroidism

[ ]  Hyperthyroidism

[ ]  IBS/IBD

[ ]  Heart disease

[ ]  Anxiety

[ ]  Asthma

[ ]  Arthritis

[ ]  Hiatal hernia

[ ]  Gout

[ ]  Frequent colds/flu

[ ]  Crohn’s disease

[ ]  High blood pressure

[ ]  Headaches

[ ]  Migraines

[ ]  Tuberculosis

[ ]  Urinary Tract Infections

[ ]  Eczema

[ ]  Kidney Infection

[ ]  Kidney stones

[ ]  Macular degeneration

[ ]  Rapid weight loss

[ ]  Rapid weight gain

[ ]  Diabetes

[ ]  Mental illness

[ ]  Pneumonia

[ ]  Interstitial cystitis

[ ]  Psoriasis

[ ]  Alcoholism

[ ]  Drug addiction

[ ]  Glaucoma

[ ]  GERD

[ ]  Hypoglycemia

[ ]  Depression

[ ]  Tonsillitis

[ ]  Hemorrhoids

[ ]  Gall stones

[ ]  Candidiasis (yeast overgrowth)

[ ]  Ulcer

[ ]  Celiac disease

[ ]  Chronic fatigue syndrome

[ ]  Fibromyalgia

[ ]  ADHD/ADD

[ ]  Autoimmune conditions (please list): Click here to enter text.

[ ]  Cancer (please list): Click here to enter text.

Dental problems: [ ]  Mercury amalgams [ ]  Toothache [ ]  Bleeding gums [ ]  Gum diease

**Check any conditions you have had previously that you no longer have:**

[ ]  Chicken Pox

[ ]  Seasonal Allergies

[ ]  Parasites/Giardia

[ ]  Eating disorder

[ ]  Hepatitis

[ ]  Hypothyroidism

[ ]  Hyperthyroidism

[ ]  IBS/IBD

[ ]  Heart disease

[ ]  Anxiety

[ ]  Asthma

[ ]  Arthritis

[ ]  Hiatal hernia

[ ]  Gout

[ ]  Frequent colds/flu

[ ]  Crohn’s disease

[ ]  High blood pressure

[ ]  Headaches

[ ]  Migraines

[ ]  Tuberculosis

[ ]  Urinary Tract Infections

[ ]  Eczema

[ ]  Kidney Infection

[ ]  Kidney stones

[ ]  Macular degeneration

[ ]  Rapid weight loss

[ ]  Rapid weight gain

[ ]  Diabetes

[ ]  Mental illness

[ ]  Pneumonia

[ ]  Interstitial cystitis

[ ]  Psoriasis

[ ]  Alcoholism

[ ]  Drug addiction

[ ]  Glaucoma

[ ]  GERD

[ ]  Hypoglycemia

[ ]  Depression

[ ]  Tonsillitis

[ ]  Hemorrhoids

[ ]  Gall stones

[ ]  Candidiasis (yeast overgrowth)

[ ]  Ulcer

[ ]  Celiac disease

[ ]  Chronic fatigue syndrome

[ ]  Fibromyalgia

[ ]  ADHD/ADD

[ ]  Autoimmune conditions (please list): Click here to enter text.

[ ]  Cancer (please list): Click here to enter text.

**Birth History**

[ ]  Term [ ]  Premature Any pregnancy/birth complications? Click here to enter text.

[ ]  Breast fed, if yes how long? Click here to enter text. [ ]  Bottle fed

Did you eat a lot of candy or sugar as a child? [ ] Yes [ ] No

What were your favorite foods as a child? Click here to enter text.

**Women Only**

**Menstruation History**

Age at first period Click here to enter text.

Menses frequency (e.g. every 28 days): Click here to enter text. Length (e.g. 10 days): Click here to enter text.

Cramping [ ] Yes [ ] No

Clotting [ ] Yes [ ] No

Ever skipped your period? [ ] Yes [ ] No For how long? Click here to enter text.

**Check all that apply**

[ ]  Fibrocystic breasts

[ ]  Increased sex drive

[ ]  Decreased sex drive

[ ]  PMS

[ ]  Endometriosis

[ ]  Heavy periods

[ ]  Facial hair growth

[ ]  PCOS

[ ]  Fibroids

[ ]  Abnormal PAP

[ ]  Infertility

[ ]  Endometriosis

Have you ever used hormonal contraceptives (e.g. IUD, birth control pill, etc.): [ ] Yes [ ] No

When? Click here to enter text. For how long? Click here to enter text. Type? Click here to enter text.

Number of Pregnancies Click here to enter text. Number of living children Click here to enter text.

Date of last PAP Click here to enter text.

Result of last PAP Click here to enter text.

**Are you in menopause?**  [ ] Yes [ ] No Age at menopause Click here to enter text.

Check all that apply:

[ ]  Hot flashes

[ ]  Mood swings

[ ]  Weight Gain

[ ]  Incontinence

[ ]  Concentration/memory problems

[ ]  Vaginal dryness

[ ]  Decreased libido

[ ]  Depression

Use of hormone therapy [ ] Yes [ ] No For how long? Click here to enter text.

Date of last Mammogram/result? Click here to enter text.

**Is there anything else I should know?** Click here to enter text.