Patient Name: ______________________________ **Age:** ___________ **DOB:** ____/____/_____

Please list in order of importance the health concerns that you would like addressed:

1) ____ 3) ____

2) ____ 4) ____

How do your health concerns limit you: ____

How committed are you towards making valuable changes: Little Moderately Very

Past Medical History

Rheumatic Fever	Y N	Anemia	Y N	Hepatitis or Liver Disease	Y N
High Cholesterol	Y N	Arthritis	Y N	Kidney Disease	Y N
Heart Attack, Stroke or other Cardiovascular Disease	Y N	Autoimmune Disease	Y N	Inflammatory Bowel Disease or Irritable Bowel Syndrome	Y N
High Blood Pressure	Y N	Thyroid Disease	Y N	Osteoporosis/ Osteopenia	Y N
Diabetes	Y N	Frequent or Chronic Infection	Y N	Mental Illness	Y N
Asthma	Y N	Sexually Transmitted Disease	Y N	Substance or alcohol abuse	Y N
Seizures	Y N	HIV or AIDS	Y N	Cancer-type:	Y N

Did you receive all available vaccinations?____

List any surgeries, hospitalizations, or serious illnesses, including date occurred:

1) ____________________________________ 4) ____________________________________

2) ____________________________________ 5) ____________________________________

3) ____________________________________ 6) ____________________________________

Please list the medicines, nutritional supplements, and herbs that you are taking. Include dosages.

____

____

____

____

Please list all known allergies including environmental and food:

____

Typical Day's Diet

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Patient Name: ______________________________ **DOB:** ______________

Social History

Who do you live with? **Spouse/Significant Other/ Partner** **Kids** **Parents** **Self** **Friends**

Quality of significant relationships: ______________________________

Do you have pets? ______________ **What are your hobbies?** ______________________

Enjoy your job? **Y N** **Hours worked per week**: _______ **Occupation**: ________________

Past or current use of recreational drugs, alcohol, or cigarettes? Y N

Use of coffee, black tea, soda, or energy drinks? Y N

Family History

	Father	Mother	Grandparents	Siblings	Children
Age if living:					
Age deceased:					
Reason for death:					
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N
CVD/Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N
Alzheimer's/Dementia:	Y N	Y N	Y N	Y N	Y N
Cancer:	Y N	Y N	Y N	Y N	Y N
Diabetes:	Y N	Y N	Y N	Y N	Y N
Arthritis:	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N
Substance Abuse:	Y N	Y N	Y N	Y N	Y N
Thyroid Disease:	Y N	Y N	Y N	Y N	Y N
Autoimmune disease:	Y N	Y N	Y N	Y N	Y N
Celiac Disease:	Y N	Y N	Y N	Y N	Y N

Toxin Exposure

Did you grow up near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ____

____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?

____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? ______________________________

Are you particularly sensitive to perfumes, gasoline or other vapors? ______________________

Do you use pesticides, herbicides or other chemicals around your home? ____________________

If so, which ones? ____