



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? _____