HEALTH RECORD – CONFIDENTIAL INFORMATION

of _____ *date* _____

Name: _____ Date: _____

Address: _____

Postal code: _____ City: _____

Telephone (Daytime): _____ Telephone (Evenings): _____

Mobile : _____ E-mail address: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ BMI _____ Blood Type: A B O AB

Date of birth: month/day/year _____

Your occupation / Environment: _____

Main Health Complaint / Symptoms:_____

List one to five health goals you would like to attain for yourself, in order of priority:

(How long have these been a concern for you?)

1.

2.

3.

4.

5.

"I haven't felt well since" – _____

What do you believe or suspect is the reason for your condition? _____

_____

What were the 3 most stressful moments in your life?

1.

2.

3.

What do you worry about most in your life? _____

What nurtures you? _____

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Family history

Hereditary diseases? _____

Father – age ____ health status: _____

Mother – age ____ health status: _____

Brother – age ____ health status: _____

Sister – age ____ health status: _____

Do you smoke now? _____

In the past? _____ for how long? _____

What foods do you crave? _____

Past conditions or other health information you would like us to know with dates. Please include childhood illness.

What physical trauma/accidents have you experienced?

_____

_____

Have you ever been hospitalized? If yes, when? Why? _____

_____

Surgeries (appendix, GB, tonsils): _____

Medical Conditions: _____

Medications: _____

_____

Allergies / Reactions to meds: _____

List any OTC drugs, recreational drugs, vitamins, herbal or homeopathic medicines you are taking and the dosages:

_____

_____

Exercise:

What kind _____

Frequency? _____

How is your concentration/focus? _____

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Bowel function: # per day? _____

Type: strained, loose, soft, hard, very thin, diarrhea, explosive, constipated, undigested food, blood or mucus in stool

Sleep habits: What time do you go to bed? _____ Get up? _____

Fall asleep easily? Yes No Restless sleeper? Yes No Wake up during night? Yes No

Do you feel rested when waking? Yes No Do you snore? Yes No

Do you have sleep apnea? Yes No What position do you sleep in? _____

Menstrual cycle: Regular cramping PMS yeast/bladder infections

Last period: _____

Birth control pills? Yes No Hormone Replacement therapy? Yes No

Anything missed? What could get in the way of your making changes? Have you gone on "diets" in the past? How did they work?