Confidential Health History

Name:
Address:
Email address:
Phone:
Age:_____ Height _____ Date of Birth _____ Place of Birth _____

Current weight: _____ Weight six month ago _____ One year ago _____
Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____ Children? _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns:

When was the last time you felt really vibrant and well?

Other current major life concerns?

If you could wave a magic wand and change 2 things about your life right now, what exactly would they be?

Any serious illness, hospitalization, injuries, and surgeries, either now or in your past?

How is the health of your mother?
If deceased, relay illnesses.
How is the health of your father?
If deceased, relay illnesses.
What is your ancestry? _____What blood type are you? ___
Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____
If not, why?
_____

Any ongoing sources of inflammation (e.g eczema, or other skin irritation, chronic post nasal drip, congestion, headache, achy muscles/joints, swelling, pain, stiffness)?
_____

(This section for women only)
Are your periods regular?_____ How many days is your flow? _____ How frequent?_____

Painful or symptomatic? _____ Please explain:_____
Birth control history:_____
Vaginal infections, reproductive concerns? _____

Do you struggle with constipation, diarrhea, gas, distension, belching, or bloating: Which?
Please explain in detail: _____
_____

Please list ALL supplements or medications you take (prescription or over-the-counter) and frequency?_____
_____
_____

Have you ever taken antibiotics more than a short course or two as a child? If so, when/how often? For what? And for how long? _____
_____

Any remarkable exposure to toxins (e.g.current or childhood home, nearby industrial community, job, hobbies, travel, pesticides, heavy metals)?

What is the general status of your dental health/care?

How many silver/mercury fillings do you have? Other major dental work/issues beyond basic cleanings?

On a scale of 1-10, how would you rate your general energy level (1=lowest)?_____
To what do you attribute this energy level?

Any healers,helpers, pets or therapies with which you are involved? Please list:
_____

What are your primary hobbies?
What role do sports and exercise play in your life?
What do you do to relax? How often?

What was your general health and well-being as a child?

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____

Do you have any known food allergies or sensitivities?

What percentage of your food is home-cooked? _____ What percentage is not?____
Where do you get the rest from? _____

If you crave sugar, carbs, alcohol, coffee, cigarettes, other foods, or have any addictions?

Anything else you would like to share?

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0- Never or almost never have the symptoms
1- Occasionally have it, effect is not severe
2- Occasionally have it, effect is severe
3- Frequently have it, effect is not severe
4- Frequently have it, effect is severe

HEAD

_____ Headache
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itching eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness) Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Canker sores Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain Total _____

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas

_____ Heartburn
_____ Intestinal/stomach pain Total _____

JOINT/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ Inability to urinate or low urine flow
_____ Low libido or other sexual dysfunction
_____ Women: Breast fibroids
_____ Women: Painful or tender breasts
_____ Women: Uterine fibroids Total _____

Grand Total _____