Health History and Evaluation Form

Personal:

First Name_____ Last Name_____ Date_____

Address_____

City_____State_____Zip_____

Phone (_____)_____ Email_____

Birthdate_____ Age_____ Place of Birth_____

Height_____ Current Weight_____ Would you like your weight to be different? _____

If so, how? _____

Social:

Relationship status_____

Where do you live? _____ Where do you work? _____

Occupation_____ Full-time, Part-time, Other_____

Children? Y/N_____ How many? _____ Ages? _____

Pets? _____

General Health

What are your main health concerns?

_____
_____
_____
_____
_____

How have you dealt with these concerns? (doctors, self-care)

_____
_____
_____
_____
_____

Any current or history of serious illnesses, hospitalizations, or injuries?

_____
_____

Any other concerns?

_____

_____

At what point in your life did you feel your best? _____

How is your sleep? _____

Do you wake up during the night? If so, why? _____

Any pain, stiffness, or swelling? _____

Any constipation, gas/bloating or diarrhea? _____

Any allergies or sensitivities? _____

Are your periods regular? _____ How many days is your menstruation? _____ How frequent? _____

Are your periods painful or symptomatic? If so, please explain _____

Have you reached or are you approaching menopause? _____

What is your current and/or history of birth control? _____

Do you experience yeast infections and/or urinary tract infections? _____

Health Evaluation

List any supplements and/or prescription medications you are currently taking

_____

_____

_____

_____

Do you have any previous experiences with a holistic health practitioner? _____

What is your family health history? _____

Food and Lifestyle

Will your family and friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____ What % of meals do you cook at home? _____

Where does your non-home-cooked food come from? _____

Do you have any addictive behaviors with the following (circle all that apply)?

- Nicotine
- Caffeine
- Alcohol

- Recreational Drugs
- Prescription Drugs
- Sugar
- Other _____

What were your diet and eating habits like growing up? _____

_____

_____

Describe your diet at the onset of your health problems

_____

_____

How has your diet changed in relation to your health problems? Diet History?

_____

_____

_____

Describe the foods you eat when you are:

1. Hungry: _____
2. Angry: _____
3. Lonely: _____
4. Tired: _____
5. Depressed: _____
6. Celebrating: _____

How is your mood and energy level affected by eating these foods?

_____

_____

_____

On a scale of 1 to 10, 1 being the worst and 10 being the best, describe your overall energy levels (circle one).

1 2 3 4 5 6 7 8 9 10

What is the most important thing you feel you should change to improve your health?

_____

_____

Is there anything else you would like to share?

_____

_____


FOOD LOVE HEAL
Restore Your Core