Name: _____ Date: _____

Address: _____

Phone # _____ E-mail: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

Blood Type: _____ Gender: M F MTF FTM _____

Preferred pronoun: he/him/his she/her/hers _____

With whom do you share your home? (partners, kids, housemates, animal friends…): _____
_____

Present Health Concerns

What parts of your health and wellness are you looking for support with?_____
_____
_____

Please list any known "medical" diagnosis:_____
_____

Please list any other health care practitioners you are currently seeing:_____
_____

Please list any allergies (to food or medicine) or foods you dislike: _____
_____

Please list any medications, herbs or supplements you are taking regularly—including prescribed, recreational or over-the-counter:_____

_____

Are you currently pregnant or actively trying to conceive?_____

Past Medical History

Please list and date any serious illnesses or operations you have had:_____
_____

Please list and date any major injuries or accidents, any physical or emotional traumas: _____
_____
_____

Family Medical History

Please note any history of cancer, stroke, diabetes, mental illness, high blood pressure, heart disease, arthritis, alzheimers or other chronic illness in parents, grandparents or siblings:_____
_____
_____
_____

Are you or any family members in a recovery program? If yes, which one? _____
_____

Self-Care

Please list your regular physical activities:_____
_____

How would you describe your energy level? _____
How many hours a night do you sleep? _____ How many hours do you need to feel rested? _____
Do you take long to fall asleep or wake during the night? _____ If so, when? _____

Each day, how frequently to you urinate? _____ Have a bowel movement? ____

Where do you hold stress in your body? _____

Choose two emotions that predominate in your life: _____ _____

Describe your (emotional) relationship to food/what you eat: _____
_____

Check the boxes below to indicate the foods included in your usual diet:

	Occasionally	Daily	Multiple Times a Day	Comments
Red Meat				
Chicken, Fish, Eggs				
Dairy (milk, cheese, yogurt)				
Soy				
Fried Foods				
Desserts/Baked Goods				
Sugar				
Fruits/Vegetables				
Leafy Greens				
Water				
Alcohol				
Coffee/ Caffeine				
Soda/ Diet Soda				
Tobacco				

Please write a food diary listing all meals, snacks, and drinks you consume over a five-day period. Include how you consume them (sitting, in the car, etc) and an approximate portion size.

Body System Health Profile

Please check any item listed below, rating it as follows:
1 = past concern 2 = experience infrequently 3 = major concern
Please leave blank if not applicable

Circulatory

___ High Blood Pressure
___ Low Blood Pressure
___ Palpitations/heart murmur
___ High cholesterol
___ Stroke
___ Pain in chest
___ Cold hands & feet
___ Poor circulation
___ Anemia
___ Swelling in ankles/joints
___ Varicose veins
___ Other: _____

Respiratory

___ Allergies
___ Asthma
___ Difficulty breathing
___ Production of phlegm? What color?____
___ Sinus congestion
___ Lung congestion
___ Sore throat
___ Hay fever
___ Frequent Colds
___ Frequent Bronchitis
___ Other: _____

Eyes, Ears, Nose & Throat

___ Eye pain, wet/dry
___ Failing vision
___ Ear aches
___ Hearing loss
___ Ringing in the ears/Tinnitus
___ Vertigo
___ Cold sores
___ Canker sores/Mouth ulcers
___ Teeth/Gum Problems
___ TMJ
___ Other: _____

Skin

___ Boils
___ Acne
___ Psoriasis
___ Eczema
___ Bruise Easily
___ Slow wound healing
___ Other: _____

Gastro-intestinal

___ Poor appetite
___ Gas
___ Abdominal Pain
___ Bloating
___ Acid Reflux
___ Belching
___ Nausea
___ Vomiting
___ Hypoglycemia (Low Blood Sugar)
___ Gall Stones
___ History of Hepatitis
___ Ulcers
___ Constipation
___ Diarrhea
___ Hemorrhoids
Are your bowel movements:
___ Loose ___ Normal ___ Hard
___ Undigested food in stool
___ Blood in Stool ___ Mucous in stool

___ Other: _____

Urinary

___ UTIs
___ Bladder infections (cystitis)
___ Urgency/Frequent urination
___ Incontinence
___ Painful urination
___ Kidney or bladder stones
___ Lower back pain
___ Other _____

Musculo/skeletal

___ Stiffness/soreness
___ Joint pain/swollen joints-- where? _____
___ Torn ligaments
___ Arthritis
___ Broken bones: List: _____
___ Sprained tendons/muscles
___ Back pain—upper/lower
___ Spinal Curvature
___ Other _____

Reproductive

___ Pregnancies Date: _____Miscarriage(s) Date: _____Abortion(s) Date: _____
___ Contraceptive use: list type(s) & how long: _____
___ Sexually transmitted infections: list type if known: _____
___ Hysterectomy, Date: _____ Reason: _____
___ Uterine fibroids
___ Ovarian cysts
___ Endometriosis
___ Vaginal Bacterial Infection
___ Vaginal itching/discharge
___ Yeast Infection
___ Genital Herpes ___ HPV/Genital Warts
___ Cervical dysplasia/abnormal pap
___ Pelvic Inflammatory Disease
___ Painful intercourse
___ Breast pain
___ Congested breast tissue
___ Breast lump
___ Other _____

Menstruating Folks

___ Irregular menstrual cycles
___ Heavy menstrual bleeding
___ Painful menstrual cramps
___ Bleeding between cycles
___ Absence of menstrual cycles
___ Dramatic mood swings around menstrual cycle
___ Lack of sex drive
___ Other: _____

Menopausal Folks

___ Hot flashes
___ Mood swings
___ Vaginal dryness
___ Osteoporosis ___ Night Sweats
___ Vaginal bleeding
___ Estrogen Replacement Therapy
___ Lack of sex drive
___ Other: _____

Reproductive

___ Benign Prostatic Enlargement
___ Prostatitis
___ Sexually transmitted disease
List Type if known: _____
___ Difficulty with urination
___ Blood in urine
___ Impotence
___ Lack of sex drive
___ Infertility
___ Other:_____

Lymphatic

___ Congestion
___ Swollen glands
___ Infection
___ Drainage
___ Other: _____

Nervous System

___ Anxiety
___ Irritability
___ Stress
___ Depression
___ Insomnia
___ Fatigue
___ Headaches
___ Migraines
___ Fainting/Dizziness
___ Peripheral Neuralgia
___ Facial Neuralgia
___ Numbness
___ Shingles
___ Memory/concentration difficulty
___ Seizures
___ Other: _____

Auto Immune

___ Diabetes (Please indicate **Type I** or **Type II**)
___ Hyperthyroid
___ Hypothyroid
___ Hasimoto's Disease
___ Addison's Disease
___ Fibromyalgia
___ Scleroderma
___ Celiac's Disease
___ Ulcerative Colitis or Crohn's Disease
___ Myesthenia Gravis
___ Multiple Sclerosis
___ Chronic Fatigue Syndrome
___ Lupus
___ Rheumatoid Arthritis
___ Other: _____