

CLIENT HISTORY

Name: _____
 Address: _____
 E-mail: _____
 Sex: _____ Age: _____ DOB: _____

Date: _____
 Phone: _____
 Referred by: _____

MEDICAL HISTORY

Please list the main health issues that you have in order of their importance. List the symptoms and related information of each of these issues. Please also rate your symptoms by degree of severity, on a scale of 1 – 5 [1 = mild, 5 = very severe].

Health Issues	Symptoms	Rate 1-5	Related Info. [Duration, Treatments, How it Started, What makes it Better/ Worse]
1.			
2.			
3.			
4.			
5.			

Current Medications	Current Supplements

Do you? Please ✓	If so, how much ?	Over what time period ?	Do you ? Please ✓	If so, how much ?	Over what time period ?
<input type="checkbox"/> Smoke Tobacco			<input type="checkbox"/> Use Caffeine		
<input type="checkbox"/> Chew Tobacco			<input type="checkbox"/> Drink Sodas		

Do you? Please ✓	If so, how much ?	Over what time period ?	Do you have any other addictions?	How much ?	Over what time period ?
<input type="checkbox"/> Drink Alcohol			<input type="checkbox"/> _____		
<input type="checkbox"/> Use Drugs			<input type="checkbox"/> _____		

List Drug Allergies	What kind of reaction to drug?	Supplement Allergies	Food Allergy	Inhalant Allergy	Chemical Allergy
			<input type="checkbox"/> Milk Products	<input type="checkbox"/> Dust	<input type="checkbox"/> Chlorine, Formaldehyde
			<input type="checkbox"/> Wheat, Grains	<input type="checkbox"/> Grass, Pollen	<input type="checkbox"/> Cosmetics, Perfumes
			<input type="checkbox"/> Soy	<input type="checkbox"/> Mold	<input type="checkbox"/> Detergents, Cleaners
				<input type="checkbox"/> Animal Dander	<input type="checkbox"/> Gas, glues, paint, dyes
					<input type="checkbox"/> Newsprints, petrochem

Family History

Condition	You	Family Members
Alcoholism		
Anemia		
Anxiety		
Arthritis		
Asthma / Bronchitis		
Autoimmune Disease		
Bladder / Kidney		
Bleed Easily		
Cancer		
Depression		
Diabetes		
Digestive / Intest. Prob		
Ear / Eye Problems		
Eating Disorders		
Genetic Condition		
Gout		
Headaches		
Heart Disease		
High Blood Pressure		

Condition	You	Family Members
HIV / AIDS		
Hyperactivity / ADHD		
Learning Disability		
Muscle Problems		
Neurological Problems		
Osteoporosis		
Psychological Problems		
Rheumatic Fever		
Seizure Disorders		
Sex Trans. Disease		
Sinus / Respiratory		
Skin / Eczema / Acne		
Stroke		
Swallowing Disorder		
Thyroid Disease		
TMJ		
Tuberculosis		
Viral Disorder		
Weight Loss / Gain		

Other: _____

DIET HISTORY

What types of fats and oils (butter, margarine, etc) do you use? _____

What types of protein (meat, eggs, dairy, fish, soy, etc.) do you eat? _____

How often do you eat flour products (bread, pasta, etc.)? _____

What fruits and vegetables do you eat and how much? _____

Are there any foods you are sensitive to? _____

What do you drink and how much? _____

What types of sweets and snacks do you eat? _____

Do you skip meals? Which ones and how often? _____

Do you have any cravings? What and when? _____

Are you trying to lose or gain weight? Have you dieted in the past? _____
