



Health History Questionnaire

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Phone: 810 869-8898

Name _____ Date of Birth _____ Gender _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Alternate Number _____ E mail _____

Referred by: _____

Medical History: Check any diseases that you or your relatives have had:

	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Gout	Hypertension	Hypothyroid	Kidney	Neurobiological	Stomach Ulcer	Periodontal	Tuberculosis	Osteoporosis	Obesity	Heart/Stroke/
You																	
Father																	
Mother																	
Brothers																	
Sisters																	
Spouse																	
Children																	
Grandchildren																	

Check any other illnesses that you currently have, or have had previously:

Abscesses

Acne

Alcoholic

Allergies

Alopecia/Hair Loss

Anemia

Attempted Suicide

Arteriosclerosis

Back Problems

- | | | |
|--|---|---|
| <input type="checkbox"/> Benign Breast Tumor | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Candida/Thrush | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Excessive Fatigue |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hives | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Lupus | <input type="checkbox"/> Major Surgery |
| <input type="checkbox"/> Minor Surgery | <input type="checkbox"/> Malaria | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Myopia | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatoid Arthritis |

Scarlet Fever

Sciatica

Skin Ulcers

Skipped Heart Beats

Stroke

Syphilis

Thyroid Disease

Ulcerative Colitis

Vision Problems

Current Weight: _____

Desired Weight: _____

Height: _____

Other Illnesses _____

Additional Details _____

Reason for Seeing a Nutritional Counselor _____

Along with this completed form provide the following information:

1. A copy for my file of recent and/or significant laboratory test results. I like to make notes on my copy during our appt .
2. A 3-day diet record.

"Write down every thing that you eat for 3 days. Include quantities, type of food, brand name, whether or not it was homemade, store bought, or from a restaurant. Include any beverages including water. Try to be as complete as possible. Include time of day the meal was consumed and how you felt afterwards. On the quantities, an estimate is fine, the food does not have to be weighed. I find it is best if you keep a journal with you for those 3 days and write down the food as you consume it."

3. A list of any medications and/or supplements that you are currently taking, including the dosage, brand, and time of day. Creating this list saves time during our appointment for other important tasks. You may also bring the containers.

***Please Note:** If you need to cancel an appointment please do so 24 hours in advance. There is a **\$80** fee for not cancelling an appointment 24 hours in advance.

Initials: _____