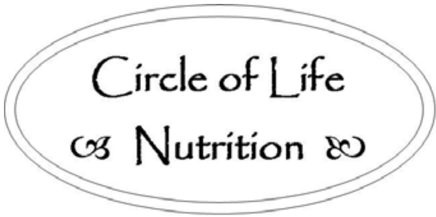
Print Form



Health History Questionnaire

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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	Peridontal	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

- [ ] Benign Breast Tumor
- [ ] Bleeding Gums
- [ ] Bronchitis
- [ ] Candida/Thrush
- [ ] Cataracts
- [ ] Chest Pains
- [ ] Chicken Pox
- [ ] Cirrhosis
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diphtheria
- [ ] Diverticulosis
- [ ] Drug Addition
- [ ] Ear Infections
- [ ] Eczema
- [ ] Emphysema
- [ ] Endometriosis
- [ ] Excessive Fatigue
- [ ] Eye Disease
- [ ] Fainting or Dizzy Spells
- [ ] Gall Stones
- [ ] Gastritis
- [ ] Gingivitis
- [ ] Goiter
- [ ] Gonorrhea
- [ ] Hay Fever
- [ ] Headaches
- [ ] Hearing Problems
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] Hernia
- [ ] Herniated Disc
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] Hives
- [ ] Insomnia
- [ ] Jaundice
- [ ] Kidney Stones
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] Lupus
- [ ] Major Surgery
- [ ] Minor Surgery
- [ ] Malaria
- [ ] Measles
- [ ] Mononucleosis
- [ ] Multiple Sclerosis
- [ ] Mumps
- [ ] Myopia
- [ ] Nervous Breakdown
- [ ] Nervousness
- [ ] Neuralgia
- [ ] Night Blindness
- [ ] Numbness
- [ ] Pancreatitis
- [ ] Persistent Cough
- [ ] Polio
- [ ] Psoriasis
- [ ] Rheumatic Fever
- [ ] 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 **$90** fee for not cancelling an appointment 24 hours in advance.

Initials: ____________