Name: Date:

Address:

Telephone: Best time to call:

Email:

Date of birth: Preferred pronoun:

Height: Weight:

Occupation:
Typical schedule:

Current health practitioner(s) you work with:

Current prescription medications, herbs, or supplements:

Current over-the-counter medications, herbs, or supplements:

Have you ever had an adverse reaction to any medication or herb?

Please describe your most important health concern(s):

Dietary Summary

	Breakfast	Lunch	Dinner	Snacks
Time				
Best				
Worst				

Water intake:

Other fluids:

Food cravings:

Food allergies/intolerances/sensitivities:

Food preferences (circle all that apply)

◉ sweet ○ sour ○ salty ○ bitter ○ spicy

Do you prefer cooked foods or raw/cold foods?

Eating schedule/habits (include snacks, etc):

Typical eating environment (at home, at work, sitting, standing, while driving, etc…):

How often do you prepare your own food?

Frequency of consumption (how many servings/week)

_____coffee/caffeinated tea
_____alcoholic beverages
_____eating out
_____animal protein
_____dairy
_____soda
_____sweets
_____fresh fruits/vegetables
_____soy products
_____gluten

Medical and Family History:
For the following, please note if they apply to your mother, father, siblings, and/or self

_____Diabetes
_____Heart disease
_____Stroke
_____High blood pressure
_____High cholesterol
_____Depression
_____Mental illness
_____Other

_____Autoimmune disease
_____Tumor(s), cancer
_____Substance abuse/addiction
_____Arthritis
_____Liver disease
_____Kidney disease
_____Reproductive/sexual disease

Circumstances of your birth (C-section, difficult labor, etc):

Do you have any children?
Age(s):

For the following, please include dates and length of illness and recovery:

Major injuries:

Surgical operations:

Other hospitalization:

Recent illness:

Childhood illness(es):

How much, how often?
Do you smoke – tobacco ☐, cannabis ☐? Vape? ☐ _____
Do you use smokeless tobacco? ☐ _____
Do you use recreational drugs? (Which?) _____

Allergies to medications, chemicals, and environmental factors (pollen, dust, etc):

For the following, please check any that apply, and provide additional information as needed:

Digestive health:

_____Poor appetite
_____Gingivitis/Periodontal disease
_____Frequent burping
_____Heartburn (how often?)
_____Gas
_____Intestinal pain/cramping
_____Constipation
_____Incomplete digestion
_____Nausea (when – how?)
_____Cavities
_____Stomach pain/cramping
_____Acid reflux
_____Bloating
_____Frequent antibiotic use
_____Diarrhea
_____Blood in stool

Frequency of bowel movements:

Quality of bowel movements (color/consistency):

Kidney and urinary system health:

_____Dull pain in lower back
_____Kidney stones
_____Yeast infection(s)
_____Bladder control problems
_____Painful urination
_____Swelling in hands/feet
_____Urinary tract infection(s)
_____Water retention
_____Frequent urination
_____Decreased urine flow

Frequency of urination:

Quality of urine (color/odor):

Respiratory system health:

_____Nasal congestion (when?)
_____Tenderness around eyes/back of neck
_____Asthma
_____Bronchitis (when?)
_____Pneumonia (when?)
_____Frequent lung congestion
_____Shortness of breath
_____Sinus infections
_____Morning stuffiness
_____Wheezing upon exertion
_____Hoarseness/sore throat
_____Tuberculosis (when?)
_____Recurrent cough
_____Hyperventilation

Mucus production in nose and/or lungs? How often?

Color of mucus: Thickness:

Stress:

_____Fatigue
_____Low energy in morning
_____Low energy in evening
_____Job stress
_____Debilitating disease
_____Relaxation/meditation program
_____Easily tired
_____Low energy in afternoon
_____Anemia
_____Family stress
_____Current or past trauma

How do you handle stress?

Specific stressors right now:

Favorite time of the day: Of year:

Favorite type of weather:

Exercise frequency, type, and duration:

Sleep:

	Bedtime	Waking Time
Weekday		
Weekend		

_____Sleep less than 6 hours/night
_____ Bedtime routine
_____ Disruptive midnight waking
_____Sleep more than 8 hours/night
_____Lying in bed waiting to sleep (how long?)
_____Dreams

Cardiovascular (heart, blood vessels, and circulation) health:

_____High blood pressure
_____Stroke
_____"Hardening of the arteries"
_____Arrythmia
_____Cold hands/feet
_____Bruise easily
_____Rarely sweat
_____Pain/cramping in legs
_____Chronic wounds/ulcerations on feet/legs
_____Heart attack
_____Congestive heart failure
_____Heart palpitation
_____Heart valve dysfunction
_____Numbness/tingling in fingers or toes
_____Sweat easily
_____Varicose veins
_____Swelling in hands/feet/ankles

Blood pressure: Resting heart rate (bpm):

Total Cholesterol: HDL: LDL:

Immune function:

_____Frequent illness
_____Fever (temperature)
_____Dust allergies
_____Pet allergies
_____Reactions to vaccines
_____Muscle tenderness/soreness
_____Recurrent infections
_____Wounds heal slowly/prone to infection
_____Seasonal allergies
_____Mold allergies
_____Chemical sensitivity
_____Sensitivity to medication
_____Joint tenderness/soreness
_____Recurrent rashes/skin irritation

Immunization(s) received:

When you get sick, how do your symptoms first manifest?

Chronic conditions:

Metabolic function:

_____Diabetes/pre-diabetic/insulin-resistant
_____Nighttime hunger
_____Light-headed before meals
_____Thyroid disease/dysfunction
_____Hepatitis
_____Jaundice
_____Frequently hot
_____Overweight
_____Abdominal pain
_____Hypoglycemia
_____No morning appetite
_____"Heaviness" after meals
_____Hormonal dysfunction
_____Cirrhosis
_____Alcohol/drug abuse
_____Frequently cold
_____Underweight
_____Ringing in the ears

Fasting blood glucose level (if known):

Nervous system health:

_____Anxiety
_____Depression
_____Head injury
_____"Pinched nerve"
_____Mental illness
_____Radiating or shooting pain
_____Tremors/shaking
_____Chronic tension
_____Memory problems
_____Panic attacks
_____Spinal injury
_____Herniated disks
_____Paralysis
_____Numbness/tingling
_____Sciatic nerve pain
_____Poor muscle control
_____Headache (how often?)

Headache/pain recurrence: daily ☐ weekly ☐ monthly ☐ seasonal ☐

Aggravating factor(s) for headache/pain recurrence:

Muscle/bone/joint health:

_____Cavities in childhood
_____Brittle nails
_____Broken bones
_____Carpal tunnel
_____Arthritis
_____Chronic tension – location? triggers?
_____Cavities in adulthood
_____Osteoporosis
_____Muscle pain
_____Tendonitis
_____Chronic swelling/inflammation

Reproductive health:

_____Using birth control medication
_____Uterine fibroids
_____Endometriosis
_____Breast tenderness
_____Pregnant
_____Painful intercourse
_____Sexually active
_____Underactive libido
_____Urinary difficulties
_____Prostate cancer
_____Painful intercourse
_____Erectile dysfunction (impotence)
_____Using hormone replacement therapy
_____Uterine cysts
_____Premenstrual symptoms
_____Breast lump(s)/fibrocystic tissue
_____Infertility
_____Reproductive hormone imbalance(s)
_____Sexually satisfied
_____Overactive libido
_____Prostatitis / BPH
_____Testicular cancer
_____Painful ejaculation
_____Current or past STI

Menstrual cycle (if not menstruating, describe your cycle in the past):
Duration (days): Frequency (days): Regular?

Blood flow (heavy, medium, light):

Clotting blood in menstrual flow? Unpredictable cycle?

Tampons / pads / other?

History of pregnancy and labor:

Results of last gynecological exam/pap smear:

Emotional/Spiritual/Social health:

What are the predominant emotions in your life (circle all that apply):

☐ compassion	☐ anger	☐ rage	☐ joy
☐ nostalgia	☐ love	☐ grief	☐ jealousy
☐ sadness	☐ worry	☐ excitement	☐ inspiration
☐ regret	☐ fear	☐ anticipation	☐ anxiety
☐ apathy	☐ emptiness		

other:

How are your relationships . . .

With family:

With friends:

With your partner:

With your community:

Do you have a network for support you can call on?

What do you do for fun? What do you do to relax?

What in your life gives you a feeling of fulfillment?

I always wanted to be _____

I always wanted to do _____

Do you have a spiritual practice? How does it make you feel?

Please attach results of lab work and any relevant testing.