Name: Date:

City of Residence:

Email:

Telephone: Best time to call:

Date of birth: Preferred pronouns:

Occupation:

Typical schedule (work, classes, commitments, etc):

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):

What have you already tried? What was helpful, and what didn't help?

If you could change one thing about your health with a wish, what would it be?

How much, how often?

Do you… smoke___ / vape___ – tobacco___, cannabis___, other___? _____
Do you use smokeless tobacco? _____
Do you use recreational drugs? (Which?) _____

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

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

_____Diabetes _____Autoimmune disease

_____Heart disease _____Tumor(s), cancer

_____Stroke _____Substance abuse/addiction

_____High blood pressure _____Arthritis

_____High cholesterol _____Liver disease

_____Depression _____Kidney disease

_____Mental illness _____Reproductive/sexual disease

_____Other

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

Childhood illness(es):

Do you have any children?
Age(s):

Circumstances of labor and delivery:

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

Major injuries:

Surgical operations:

Other hospitalization:

Recent illness:

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

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 cope with stress?

Specific stressors right now:

Rhythms & Sleep:

Favorite time of the day: Of year:

Favorite type of weather:

Exercise frequency, type, and duration:

	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 health:

_____High blood pressure
_____Stroke
_____"Hardening of the arteries"
_____Arrhythmia (irregular heartbeat)
_____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: Triglycerides:

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
_____AD[H]D
_____Bipolar
_____Epilepsy
_____Head injury
_____"Pinched nerve"
_____Numbness/tingling
_____Sciatic nerve pain
_____Poor muscle control
_____Headache (how often?)
_____Panic attacks
_____OCD
_____Depression
_____Spinal injury
_____Herniated disks
_____Paralysis
_____Radiating or shooting pain
_____Tremors/shaking
_____Chronic tension
_____Memory problems

Headache/pain recurrence: daily weekly monthly seasonal

Aggravating factor(s) for headache/pain recurrence:

Musculoskeletal 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

Skin health:

_____Acne, boils, pustules
_____Rash
_____Dry/flaky skin
_____Eczema
_____Psoriasis
_____Damp/oily skin

Skincare routine:

Reproductive health:

_____Birth control medication (specify)
_____Uterine fibroids
_____Endometriosis
_____Premenstrual symptoms
_____Breast tenderness
_____Pregnant
_____Painful intercourse
_____Sexually active
_____Underactive libido
_____Urinary difficulties
_____Painful intercourse
_____Erectile dysfunction (impotence)
_____Hormone replacement therapy
_____Uterine cysts
_____PCOS
_____Cancer of reproductive organs
_____Breast lump(s)/fibrocystic tissue
_____Infertility
_____Reproductive hormone imbalance(s)
_____Sexually satisfied
_____Overactive libido
_____Prostatitis / BPH
_____Painful ejaculation
_____Current or past STI

Menstrual cycle (if not presently 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, or prostate exam:

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:			

Are there emotions you have difficulty accessing or expressing? (If yes, please elaborate.)

How are your relationships . . .

With family:

With friends:

With your partner[s]:

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 supportive spiritual practice or community?

Please attach results of lab work and any relevant testing.