**Health History Form**

*All information is strictly confidential.*

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Major Complaint(s), in order of significance:**

Severe Moderate Slight

1.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do the above conditions impair your daily activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Patient Medical History:**

Please list any medications you are taking, or have taken, and for how long (attach separate sheet if necessary)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medications | Reason for Taking | Year Started | Year Stopped | Dosage |
|  |  |  |  |  |
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Prescribing Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List medications you are allergic to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in improving your health to reduce your need for medication?  Yes  No  
  
Are you interested in improving your health so that your body does not rely on medication?  Yes  No

Briefly list all major past illnesses, hospitalizations, surgeries, operations, fractures, car accidents or major trauma you have experienced. Include date, outcome, etc.

Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check off any of the below surgeries you have had:

 Appendectomy  Biopsies  Dental Surgery  Gallstones  Implants/Prostheses

 Arthroscopy  Gallbladder Removal  Eye Surgery  Hysterectomy  Kidney Stones

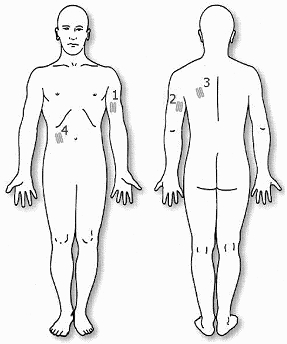
 Breast Implants  C-Section  Fracture  Hernia  Laparoscopy  Tonsillectomy

List any other Surgeries or Hospitalizations you have had (and year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other major illnesses you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Pain & Scars**

Please clearly mark any problem areas with an “x” and any scars with an “s”



If you have pain, is it:

 Sharp  Burning  Aching  Cramping  Dull  Moving  Fixed  Constant  Intermittent  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



















Do the following lessen the pain?

 Pressure  Cold  Ice  Heat  Dampness  Dryness  AM  PM

 Exercise  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do the following worsen the pain?

 Pressure  Cold  Ice  Heat  Dampness  Dryness  AM  PM

 Exercise  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific movements or activities that aggravate the pain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this condition affect your sleep in any way?  Yes  No

How bad is your pain currently on a scale from 1-10 (1 = no pain, 10 = unbearable pain):

1 2 3 4 5 6 7 8 9 10

1. **Family Medical History**

Please list (and specify if necessary) any condition that you or a member of your family has experienced.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Self | Mother/Father | Brother/Sister | Child | Grandparent  Maternal/Paternal | Aunt/Uncle |
| Alcohol/Drug Abuse |  |  |  |  |  |  |
| Allergies/Sinus |  |  |  |  |  |  |
| Anemia/Blood Disorder |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |
| Birth Defect |  |  |  |  |  |  |
| Cancer/Type |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Depression/Anxiety |  |  |  |  |  |  |
| Mental Health Disorder |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |
| Thyroid Disorder |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |

Were you breast-fed as a child:  Yes  No  Unsure  
  
Any family members with known adverse reactions to vaccines (seizure, rash, eczema, peanut allergy, etc.):   
  
 Yes  No Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IV. Dietary Assessment**

Please check the boxes in regards to how often you eat or drink the listed types of foods.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | More than  Once Daily | | Daily | 3 Times  per week | Once per week | Twice a month | Less or Never |
| Grains, Breads, Cereals  **Milk & Dairy Products**  Eggs  **Meat, Poultry, Fish**  Beans, Peas & Legumes  **Fruits**  Vegetables  **Soy Products**  Nuts & Seeds  **Popcorn & Chips**  Spicy Food  **Chocolate**  Caffeine  **Alcohol**  Soda, Sugar or Candy  **Fast Food** | |                                | | | | | | |

Are you on a special diet?  Yes  No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any known food allergies, sensitivities or intolerances (ie lactose, gluten)?  Yes  No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any supplements you are taking, or have taken, and for how long:**

|  |  |  |  |
| --- | --- | --- | --- |
| Supplement | Reason for Taking | Year Started | Year Stopped |
|  |  |  |  |
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1. **Lifestyle (Sleep, Exercise, Stress)**

Rate your sleep quality. Check all that apply

 Wake up tired  Nightmares  Restless Legs  Teeth Grinding  Other: \_\_\_\_\_\_\_\_\_\_\_\_

 Sleep Apnea  Snoring  Difficulty falling asleep  Wake up during the night (usually at: \_\_\_\_)

What time do you usually go to sleep? \_\_\_\_\_\_\_\_ How many hours do you sleep per night on average? \_\_\_\_\_\_\_

Do you exercise? Yes No If yes, what type of exercise?

 Walking  Spinning  Marathon (full / half / frequency per year: \_\_\_\_\_\_\_\_\_)

 Running  Dance  Martial Arts (please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

 Weightlifting  Aerobics  Team Sports

 Triathlon  Cross Fit  Kettle Bell Training

 Biking  General Cardio  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you exercise:  1-2 times per week  3-4 times per week  5+ times per week

How long is your average exercise session?  30 min  60 min  90 min  over 90 min

**VI. Female Vitality Health Information**

***Women only:***

|  |  |
| --- | --- |
| Menopause:  Yes  No  Age of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Menopause confirmed with:   Bloodwork   Saliva test   No labwork confirmation. Based solely on lack of period. |
| **IMPORTANT:** If you are menopausal, complete the entire page. Describe your last period below. | |

|  |  |
| --- | --- |
| Age of first period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Menstrual cycle is always the same exact # of days?  Yes  No  List avg. # of days (1st day of period to 1st day of next period): \_\_\_\_  Rate your usual menstrual blood flow:  Heavy  Light  None  Does blood color turn brown at end of period?  Yes  No  List # of days of flow: \_\_\_\_\_\_\_ | Menstrual Cramps are:   Mild  Moderate  Severe   I take medication for cramps.    Medication name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Frequency of cramps:   Monthly   Other (describe how often):\_\_\_\_\_\_\_\_\_ |

Please check the boxes if you have a history of any of the following:  
  
 Pre-menstrual syndrome (PMS). If yes, check symptoms that apply:

 Food cravings  Irritability  Water retention  Breast swelling/tenderness

 Crying easily  Headaches  Migraines  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  Bleeding between periods   Vaginal discharge   Painful Intercourse   Sexual Dysfunction   Breast Lumps/Fibrocystic   Painful Ovulation    Every month  Every other month     Spotting    During period  Between periods |  Vaginal Infections/Yeast    How many times per year: \_\_\_\_\_\_\_\_\_\_\_\_\_   Abnormal PAP smear  What class? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date of last PAP smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please list any birth control or Hormone Replacement therapy you are using (or have used).

|  |  |  |  |
| --- | --- | --- | --- |
| Birth Control/HRT Used | Reason for Taking | Year Started | Year Stopped |
|  |  |  |  |
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Please list any Infertility Treatment

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment | Reason for choosing specific type | Year Started | # of rounds |
|  |  |  |  |
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**VI. Male Vitality Health Information**  
Please check the boxes if you have a history of any of the following:

 Benign prostatic hypertrophy (BPH)   
Completed TURP; Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Testicular pain

 Erectile Dysfunction

 Premature ejaculation

 Feeling of coldness or numbness in external genitalia

 Urinary Difficulty/pain

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
The average number of spontaneous morning erections per week:  None  1 - 4  5 - 7

If none, list the last year you can recall having them: \_\_\_\_\_\_\_\_\_

**VII. Biological Decoding**   
  
List 3 of your most wonderful life experiences:

|  |  |
| --- | --- |
| Wonderful Life Experience | Year of Occurrence |
| 1. |  |
| 2. |  |
| 3. |  |

List 3 of your most painful or difficult life experiences:

|  |  |
| --- | --- |
| Painful or Difficult Life Experience | Year of Occurrence |
| 1. |  |
| 2. |  |
| 3. |  |

**VII. Readiness Assessment**  
Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet  5  4  3  2  1

Take nutritional supplements each day  5  4  3  2  1

Keep a record of everything you eat each day  5  4  3  2  1

Modify your lifestyle (e.g. work demands, sleep habits)  5  4  3  2  1

Practice relaxation techniques  5  4  3  2  1

Engage in regular exercise  5  4  3  2  1

Have periodic lab tests to assess progress  5  4  3  2  1

**Print name:**  **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_