

Medical History
 ___ Arthritis
 ___ Allergies/hay fever
 ___ Asthma
 ___ Alcoholism
 ___ Alzheimer's disease
 ___ Autoimmune disease
 ___ Blood pressure problems
 ___ Bronchitis
 ___ Cancer
 ___ Chronic fatigue syndrome
 ___ Carpal tunnel syndrome
 ___ Cholesterol, elevated
 ___ Circulatory problems
 ___ Colitis
 ___ Dental problems
 ___ Depression
 ___ Diabetes
 ___ Diverticular disease
 ___ Drug addiction
 ___ Eating disorder
 ___ Epilepsy
 ___ Emphysema
 ___ Eyes, ears, nose, throat problems
 ___ Environmental sensitivities
 ___ Fibromyalgia
 ___ Food intolerance
 ___ Gastroesophageal reflux disease
 ___ Genetic disorder
 ___ Glaucoma
 ___ Gout
 ___ Heart disease
 ___ Infection, chronic
 ___ Inflammatory bowel disease
 ___ Irritable bowel syndrome
 ___ Kidney or bladder disease
 ___ Learning disabilities
 ___ Liver or gallbladder disease (stones)
 ___ Mental illness
 ___ Mental retardation
 ___ Migraine headaches
 ___ Neurological problems (Parkinson's, paralysis)
 ___ Sinus problems
 ___ Stroke
 ___ Thyroid trouble
 ___ Obesity
 ___ Osteoporosis
 ___ Pneumonia
 ___ Sexually transmitted disease
 ___ Seasonal affective disorder
 ___ Skin problems
 ___ Tuberculosis
 ___ Ulcer
 ___ Urinary tract infection
 ___ Varicose veins
 Other _____

Medical (Men)
 ___ Benign prostatic hyperplasia
 ___ Prostate cancer
 ___ Decreased sex drive
 ___ Infertility
 ___ Sexually transmitted disease
 Other _____

Medical (Women)
 ___ Menstrual irregularities
 ___ Endometriosis
 ___ Infertility

___ Fibrocystic breasts
 ___ Fibroids/ovarian cysts
 ___ Premenstrual syndrome (PMS)
 ___ Breast cancer
 ___ Pelvic inflammatory disease
 ___ Vaginal infections
 ___ Decreased sex drive
 ___ Sexually transmitted disease
 Other _____
 Date of last GYN exam _____
 Mammogram q + q _____
 PAP q + q _____
 Form of birth control _____
 # of children _____
 # of pregnancies _____
 ___ C-section _____
 Age of first period _____
 Date - last menstrual cycle _____
 Length of cycle _____ days
 Interval of time between cycles _____ days
 Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
 ___ Surgical menopause
 ___ Menopause

Family Health History (Parents and Siblings)
 ___ Arthritis
 ___ Asthma
 ___ Alcoholism
 ___ Alzheimer's disease
 ___ Cancer
 ___ Depression
 ___ Diabetes
 ___ Drug addiction
 ___ Eating disorder
 ___ Genetic disorder
 ___ Glaucoma
 ___ Heart disease
 ___ Infertility
 ___ Learning disabilities
 ___ Mental illness
 ___ Mental retardation
 ___ Migraine headaches
 ___ Neurological disorders (Parkinson's, paralysis)
 ___ Obesity
 ___ Osteoporosis
 ___ Stroke
 ___ Suicide
 Other _____

Health Habits
 ___ Tobacco:
 Cigarettes: #/day _____
 Cigars: #/day _____
 ___ Alcohol:
 Wine: #glasses/d or wk _____
 Liquor: #ounces/d or wk _____
 Beer: #glasses/d or wk _____
 ___ Caffeine:
 Coffee: #6 oz cups/d _____
 Tea: #6 oz cups/d _____
 Soda w/caffeine: #cans/d _____
 Other sources _____
 ___ Water: #glasses/d _____

Exercise
 ___ 5-7 days per week
 ___ 3-4 days per week
 ___ 1-2 days per week
 ___ 45 minutes or more duration per

workout
 ___ 30-45 minutes duration per workout
 ___ Less than 30 minutes
 ___ Walk - #days/wk _____
 ___ Run, jog, other aerobic - #days/wk _____
 ___ Weight lift - #days/wk _____
 ___ Stretch - #days/wk _____

Other _____
Nutrition & Diet
 ___ Mixed food diet (animal and vegetable sources)
 ___ Vegetarian
 ___ Vegan
 ___ Salt restriction
 ___ Fat restriction
 ___ Starch/carbohydrate restriction
 ___ The Zone Diet
 ___ Total calorie restriction
 ___ Specific food restrictions:
 ___ dairy
 ___ wheat
 ___ eggs
 ___ soy
 ___ corn
 ___ all gluten
 Other _____

Food Frequency
 Number of servings per day:
 Fruits (citrus, melons, etc.) _____
 Dark green or deep yellow/orange vegetables _____
 Grains (unprocessed) _____
 Beans, peas, legumes _____
 Dairy, eggs _____
 Meat, poultry, fish _____

Eating Habits
 ___ Skip meals - which ones _____
 ___ One meal/day
 ___ Two meals/day
 ___ Three meals/day
 ___ Graze (small frequent meals)
 ___ Generally eat on the run
 ___ Eat constantly whether hungry or not

Current Supplements
 ___ Multivitamin/mineral
 ___ Vitamin C
 ___ Vitamin E
 ___ EPA/DHA
 ___ Evening Primrose/GLA
 ___ Calcium, source _____
 ___ Magnesium
 ___ Zinc
 ___ Minerals, describe _____
 ___ Friendly flora (acidophilus)
 ___ Digestive enzymes
 ___ Amino acids
 ___ CoQ10
 ___ Antioxidants (e.g., lutein, resveratrol, etc.)
 ___ Herbs
 ___ Homeopathy
 ___ Protein shakes
 ___ Superfoods (e.g., bee pollen,

phytonutrient blends)
 ___ Liquid meals (Ensure)
 Others _____

I Would Like To:
ENERGY - VITALITY
 ___ Feel more vital
 ___ Have more energy
 ___ Have more endurance
 ___ Be less tired after lunch
 ___ Sleep better
 ___ Be free of pain
 ___ Get less colds and flu
 ___ Get rid of allergies
 ___ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
 ___ Stop using laxatives and stool softeners
 ___ Improve sex drive

BODY COMPOSITION
 ___ Loose weight
 ___ Burn more body fat
 ___ Be stronger
 ___ Have better muscle tone
 ___ Be more flexible

STRESS, MENTAL, EMOTIONAL
 ___ Learn how to reduce stress
 ___ Think more clearly and be more-focused
 ___ Improve memory
 ___ Be less depressed
 ___ Be less moody
 ___ Be less indecisive
 ___ Feel more motivated
LIFE ENRICHMENT
 ___ Reduce my risk of degenerative disease
 ___ Slow down accelerated aging
 ___ Maintain a healthier life longer
 ___ Change from a "treating-illness" orientation to creating a wellness lifestyle