

Date: _____

Fax completed form to: (703) 569-7406

Health History

Please write or print clearly.

Name: _____

Address: _____

Email address: _____ How often do you check email? _____

Telephone – Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationships status: _____ Children? _____

Occupation: _____ Hours of work per week: _____

Do you sleep well? _____ Do you wake up at night? _____ What times? _____

To urinate? _____ What time do you generally get up in the morning? _____

What time do you generally go to sleep at night? _____

Constipation/Diarrhea? _____ Explain: _____

What blood type are you? _____ What is your ancestry? _____

Women: Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? _____ Please explain: _____

Do you take any supplements or medications? If so, which? _____

Are there any healers, helpers or therapies with which you are involved? Please list: _____

What role does exercise play in your life? _____

Do you drink coffee, smoke cigarettes, or have any major addictions? _____

What percentage of your food is home cooked? _____ Where do you get the rest from? _____

Serious illness/ hospitalizations/ injuries? _____

What is your chief concern? _____

Other concerns? _____

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How is the health of your mother?

How is the health of your father?

Health History - Part Two

Please write or print clearly.

What foods did you eat often as a child?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What about one year ago?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

What's your food like these days?

Breakfast

Lunch

Dinner

Snacks

Liquids

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____