

## **Confidential Health History**

Name															
Full Address															
Email Address	 ;														
How often do	you che	eck your em	nail?												
Telephone-W	/ork				Home						ell				
Age		Height			Da	te of birth				Pla	ce of E	Birth			
Current Weig	ht			Weigh	nt six m	onths ago				On	e year	ago:			
Would you lik	ke your v	veight to be	differer	nt?				If so	what?						
Occupation											Н	ours Pe	r Week		
Please list ma	jor healt	th concerns	:												
When was th	e last tir	ne you felt r	eally vib	orant a	nd well	?									
Other curren	t major l	ife concern	s?												
If you would	wave a i	magic wand	l and cha	ange ty	wo thin	as what wo	ould the	ev be?							
Any serious i	llness, h	ospitalizatio	n, injuri	es, and	l surgei	ries, either ı	now or	in your p	oast?						
How is the H	ealth of	your mothe	r? (If dec	ceased	relay il	Iness)									
How is the he	ealth of	our father?	' (If dece	ased re	elav illn	ess)									
			<b>(</b>			,									
What is your	ancostry	2										/hat is v	our bloc	od type?	
Wilat is your	ancestry	·									^^	riiat is y	oui bioc	ou type:	
Do you sleep	well?			How	/ many	hours?				Wake	e up at	: night?			
Why?															
Any ongoing (e.g. eczema post nasal d muscles/join	a or othe rip, con	er skin irrita gestion, he	ition, ch adaches	s, ach	У										



## **This Section Is For Women Only**

Are your periods regular?	How many days is your flow?	How Frequent?
Painful or Symptomatic?		
Please Explain:		
Birth Control History:		
Vaginal infections, reprodu	ctive concerns?	
	End of Women's Section	
Do you struggle with Const Diarrhea, Gas, Distension, B Bloating? Which?:		
Please Explain in Detail:		
Please list ALL supplement	ts or medications you take (prescription or over-the-counter) and fr	equency?
Have you ever taken antibi	iotics more than a short course or two as a child? If so, when/how c	often? For what? And for how long?
Any remarkable exposure metals)?	to toxins (e.g. current or childhood home, nearby industrial commu	unity, job, hobbies, travel, pesticides, heavy
What is the general status	of your dental/health care?	
Any troubling dental work	or history of dental/oral infections? Dentures? Root canals?	
How many silver/mercury	fillings do you have? Other major dental work/issues beyond basi	c cleanings?
On a scale of 1 to 10, how	would you rate your general energy level (1=lowest)?	
To what do you attribute t	his energy level?	
Any healers, helpers, pets o	or therapies with which you are involved? Please list:	
What are your primary hob	obies?	



What role do sports and exe	What role do sports and exercise play in your life?								
What do you do to relax?	What do you do to relax? How often?								
What was your general hea	Ith and well-being as a child?	,							
What foods did you eat as	a child?	I							
Breakfast	Lunch	Dinner	Snacks	Liquids					
What's your food like these	e days?								
Breakfast	Lunch	Dinner	Snacks	Liquids					
Do you have any food aller	l gies or sensitivities?								
Bo you have any rood unerg	gies of sensitivities.								
NA/I	- d :- b b - d2		/hat narcantaga is nat?						
What percentage of your fo	od is nome cooked?		/hat percentage is not?						
Where do you get the rest fr	rom?								
If you have a general philosophy, mindset or approach you use when									
choosing foods, please describe it briefly									
Do you crave sugar, carbs, alcohol, coffee, cigarettes, other foods, or have any addictions?									
Anything else you would lik	ke to share?								

Please also complete the symptom questionnaire on the following 2 pages.



Symptom
Questionnaire

Please use t	his s	cale to ra	te the frequ	iency a	nd sever	ity of	symptom	s you hav	e experier	nced	over	the
past two year	ars .	If multiple	choices are	e given,	please sp	ecify	what appli	es in the c	omment co	olumn		

<u>st tv</u>	<u>wo years</u> . If multiple choices are given, please specify what applies in the comment colum
	Leave the score <b>blank</b> if you <b>Never</b> have the symptom.
	Use a 1 if you Occasionally have it and the effect is Mild.
	Use a 2 if you Occasionally have it and the effect is Severe.
	Use a 3 if you Frequently or Consistently have it and the effect is Mild
	Use a 4 if you Frequently or Consistently have it and the effect is Severe.

Category	Symptom	Score	Comments or Details, if appl.
	Headache		
l HEVD	Faintness		
HEAD	Dizziness		
	Insomnia		
	Stuffy nose		
	Sinus problems		
NOSE	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
	Chronic coughing		
	Gagging or frequent need to clear throat		
MOUTH	Sore throat, hoarseness, or loss of voice		
MOUTH	Swollen or discolored tongue, gums, or lips		
	Tooth ache or gum pain or new dental work		
	Canker sores		
	Acne		
	Hives or other allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
SKIN	Flushing or hot flashes		
	Frequently feel cold		
	Excessive sweating		
	Part of body frequently feeling numb.		
	Which?		
LIEART	Irregular or skipped heartbeat		
HEART	Rapid or pounding heartbeat		
	Chest pain		
	Chest congestion		
LUNGS	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing		
	Nausea or vomiting		
DIGESTION	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Intestinal or Stomach pain. Which?		
	Other pain in GI tract? Where?		



## (Page 2)

Please use this s	scale to rate the frequency	<sup>,</sup> and severity of	symptoms	you have experiend	ced <u>over the</u>
past two years .	If multiple choices are giver	n, please specify	what applies	in the comment colu	umn.

<u> </u>	wo years . In multiple choices are given, please specify what applies in the c
	Leave the score <b>blank</b> if you <b>Never</b> have the symptom.
	Use a 1 if you Occasionally have it and the effect is Mild.
	Use a 2 if you Occasionally have it and the effect is Severe.
	Use a 3 if you Frequently or Consistently have it and the effect is Mild
	Use a 4 if you Frequently or Consistently have it and the effect is Severe.

Pain or aches in joints	JOINTS AND MUSCLES  Stiffness or limitation of movement Pain or aches in muscles Tremor or restless leg Feeling of weakness or tiredness  Binge eating/drinking Craving certain foods  Excessive weight Compulsive eating Water retention Underweight  Fatigue, sluggishness Apathy, lethargy Hyperactivity Restlessness  Poor memory Confusion, poor comprehension Poor concentration or focus  MIND Poor physical coordination Difficulty in making decisions Stuttering or stammering Learning disabilities  MOOD MOOD Anxiety, fear, nervousness Anger, irritability, aggressiveness Prequent illness Frequent or urgent urination Inability to urinate or low urine flow Low libido or other sexual dysfunction Genital itch or discharge Women: Breast fibroids Women: Painful or tender breasts Women: Uterine/Ovarian fibroids Other	Category	Symptom	Score	Comments or Details, if appl.
Arthritis   Stiffness or limitation of movement   Pain or aches in muscles   Tremor or restless leg   Feeling of weakness or tiredness   Binge eating/drinking   Craving certain foods   Excessive weight   Compulsive eating   Water retention   Underweight   Patigue, sluggishness   Apathy, lethnargy   Hyperactivity   Restlessness   Poor memory   Confusion, poor comprehension   Poor concentration or focus   Poor physical coordination   Difficulty in making decisions   Stuttering or stammering   Learning disabilities   Mood swings   Anxiety, fear, nervousness   Anger, irritability, aggressiveness   Frequent illness   Frequent or urgent urination   Inability to urinate or low urine flow   Low libido or other sexual dysfunction   Genital itch or discharge   Women: Breast fibroids   Women: Uterine/Ovarian fibroids   Other	Arthritis   Stiffness or limitation of movement   Pain or aches in muscles   Tremor or restless leg   Feeling of weakness or tiredness   Binge eating/drinking   Craving certain foods   Excessive weight   Compulsive eating   Water retention   Underweight   Patigue, sluggishness   Apathy, lethnarry   Apat		Pain or aches in joints		
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Tremor or restless leg   Feeling of weakness or tiredness	Tremor or restless leg   Feeling of weakness or tiredness		Pain or aches in muscles		
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Excessive weight	Excessive weight		Binge eating/drinking		
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Low libido or other sexual dysfunction  Genital itch or discharge  Women: Breast fibroids  Women: Painful or tender breasts  Women: Uterine/Ovarian fibroids  Other	Low libido or other sexual dysfunction  Genital itch or discharge  Women: Breast fibroids  Women: Painful or tender breasts  Women: Uterine/Ovarian fibroids  Other		Inability to urinate or low urine flow		
Women: Breast fibroids Women: Painful or tender breasts Women: Uterine/Ovarian fibroids Other	Women: Breast fibroids Women: Painful or tender breasts Women: Uterine/Ovarian fibroids Other				
Women: Painful or tender breasts Women: Uterine/Ovarian fibroids Other	Women: Painful or tender breasts Women: Uterine/Ovarian fibroids Other	OTHER	Genital itch or discharge		
Women: Uterine/Ovarian fibroids Other	Women: Uterine/Ovarian fibroids Other		Women: Breast fibroids		
Other	Other		Women: Painful or tender breasts		
			Women: Uterine/Ovarian fibroids		
Please tally your scores for this update here: Total Symptom Score	Please tally your scores for this update here: Total Symptom Scor		Other		
			Please tally your scores for this update here:		Total Symptom Score