Health History – Healthy Solutions

Name _____ Date: _____

Address_____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

Email _____

Date of Birth _____ Weight _____ Height _____

Occupation: _____How many hours do you work per week? _____

How did you hear of Healthy Solutions? _____

Reason for consultation and/or goals: _____
_____
_____

Family History of Illness & Disease

Mother: _____
Father: _____
Brothers/Sisters: _____
Grandparents: _____

Disease(s)/Illness(es) you have been diagnosed with: _____
_____

List any medications, supplements, vitamins and over the counter medications you are currently taking. (Please include aspirin, ibuprofen, antacids): _____
_____
_____

List all surgeries or hospitalizations: _____
_____

Childhood History

Did you have any chronic illnesses as a child? □ Yes □ No If yes, what type? _____

Did you have mononucleosis? □ Yes □ No

Were you abused as a child? □ Yes □ No If yes, what type of abuse? _____

Personal Weight Loss History

What diets have you been on in the past? _____

What were your results? _____

Personal Habits

- Do you smoke? □ Yes □ No If yes, are you interested in quitting? □ Yes □ No
- Drink alcohol? □ Yes □ No How much alcohol do you drink? _____ How often? _____
- Drink coffee? □ Yes □ No If yes, how many cups a day? _____
- Drink tea? □ Yes □ No If yes, how many glasses a day? _____
- Drink diet drinks? □ Yes □ No If yes, how many per day? _____
- Drink soft drinks? □ Yes □ No If yes, how often? _____
- Drink water? □ Yes □ No If yes, how many glasses per day? _____ □ Tap Water □ Purified Water
- Used recreational drugs? □ Yes □ No If yes, what and when? _____

Recent Health History

Do you have allergies? □ Yes □ No If yes, to what? _____

How often do you get colds, flu, sinusitis, bronchitis? _____

When was the last time you had antibiotics? _____

Do you have trouble falling asleep? □ Yes □ No Do you have trouble staying asleep? □ Yes □ No

What is your energy level? □ Low □ Medium □ High What is your level of stress? □ Low □ Medium □ High

Do you have?

Sugar cravings? □ Yes □ No Carbohydrate cravings? □ Yes □ No Salt cravings? □ Yes □ No

Do you exercise? □ Yes □ No If yes, how often and what type of exercise? _____

Panic attacks? □ Yes □ No Seizures? □ Yes □ No

Bowel Movements:

How many per day? _____ Per week? _____

Routinely have diarrhea? □ Yes □ No...Constipation? □ Yes □ No …Undigested food particles? □ Yes □ No

What color is the stool normally? □ Dark Brown □ Medium Brown □ Yellow/Green □ Other _____

Dental History

Do you have mercury fillings? □ Yes □ No If yes, how many? _____ Crowns or bridges? □ Yes □ No

Root canals? □ Yes □ No If yes, how many? _____

Female Response Only

Do you use birth control pills? □ Yes □ No If yes, how long? _____

Do you use hormone replacement therapy? □ Yes □ No If yes, what? _____ How long? _____

Do you have menstrual irregularities? □ Yes □ No Do you have PMS? □ Yes □ No

Do you have breast implants? □ Yes □ No If yes, how long? _____

Have you been diagnosed with □ Endometriosis □ Fibroid tumors/cysts □ Fibrocystic breasts

Have you given birth to a child? □ Yes □ No If yes, how many? _____

Last bone scan for osteoporosis? _____ Results? _____