



Confidential Health History Form

Name Date.....

Street Address City, State, Zip.....

Phone..... Other phone..... Referred by

Date of Birth Occupation.....

Height..... Weight Body frame (S,M,L)..... Number of children

Ancestry (List all)

Exercise, recreation

Relaxation/stress reduction.....

Rate energy level (1=low, 10=high) Endurance Mental Clarity.....

Memory.....

Health concerns, short term.....

Health concerns, long term.....

Dental history

Family Health History.....

Health History

Other health practitioners currently seeing: (Please include professional designation and phone number)



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Current prescription medications

.....

Current food supplements.....

.....

Stressors

.....

Trauma/Accidents

.....

.....

Abnormal lab tests in the last 2 years

.....

Allergies to foods, airbornes, contactants

.....

Toxins encountered at work or home.....

.....

Addictions/Cravings

.....

Periods of Malnutrition/dieting.....

.....

Smoker now? How long? If in past, for how long?

Average amount of sleep per night

.....

Amount of water consumed per day

Other comments (please use more paper if necessary)

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Signature..... Date