

Health History Questionnaire

Nutritional consulting provides educational information about natural healing options that are not intended as diagnosis, prescription, treatment or cure for any disease. Nutrition suggestions should not be used as a substitute for or to countermand the advice given to you by your physician. Treating medical conditions is outside of the scope of this practice. Please see your physician for medical diagnosis and treatment.

Please list any specific issues you would like addressed: _____

Personal Profile

Date: _____

Full Name: _____

Gender: Male Female

Date of birth (mm/dd/yyyy): _____

Mailing address: (street) _____

(City, State, Zip code) _____

Home phone: _____

Cell phone: _____ Work phone: _____

Email address: _____

Occupation: _____

Hobbies: _____

Emergency contact (name, phone, email):

Health History

Age: _____ Height: _____ Weight: _____ Goal Weight: _____

Surgeries/Accidents: _____

Date of last medical exam: _____

Name and phone number of physician _____

Most recent cholesterol levels: HDL _____ LDL _____ total _____ Triglycerides _____

Please list **medically diagnosed** health issues:

Please list **suspected** medical issues: _____

Please list any eating disorders (anorexia , bulimia, etc.): _____

Has your doctor or a nutritionist put you on a restricted diet? Yes No

List all allergies (airborne and/or food) _____

Do you smoke? Yes No

Do you consume alcohol frequently? Yes No

How much water do you consume per day? _____

Do you consume sugar substitutes? Please circle

Aspartame [Equal and NutraSweet], saccharin, sucralose [Splenda], sorbitol

Are you or could you be pregnant? Yes No

Do you exercise? Please describe _____

How often and for how long? _____

Stress level: high/medium/low

List all current prescription medications:

Name	Dosage	For What Condition?

Do you take any of the following over-the-counter medications on a regular basis (3 or more times per week)?

Pain Relievers Yes No

Antacids Yes No

Laxatives Yes No

Antihistamines Yes No

Please list vitamins, minerals, herbs and any other supplements you take on a regular basis:

Name of Product	Dosage	How frequently do you take this?

Do you experience any of the following conditions on a regular basis? Please check.

- | | |
|--|--|
| <input type="checkbox"/> Heart palpitations/arrhythmia | <input type="checkbox"/> Depression/moodiness |
| <input type="checkbox"/> Arthritis/joint pain | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Addictions |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Frequent urination/extreme thirst |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Insomnia/sleep disorder |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Fibromyalgia/muscle pain | <input type="checkbox"/> Inflammation/swelling/edema |
| <input type="checkbox"/> Premenstrual Syndrome | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Stress (extreme) |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sugar cravings |
| <input type="checkbox"/> Salt cravings | <input type="checkbox"/> Candida/Yeast |
| <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> Blood sugar issues |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Frequent colds, flu, etc. |
| <input type="checkbox"/> Nerve pain | <input type="checkbox"/> Indigestion/acid reflux |
| <input type="checkbox"/> Skin problems (eczema, psoriasis, acne, etc.) | <input type="checkbox"/> Memory/Cognition problems |
| <input type="checkbox"/> Hyperthyroidism/Hypothyroidism | <input type="checkbox"/> Urinary/bladder problems |

Please list medical history of: (i.e., cancer type, stroke, heart attack, diabetes, blood disorders, mental health challenges, osteoporosis, etc.)

Grandparents (maternal – mother’s side)_____

Grandparents (paternal – father’s side)_____

Mother_____

Father_____

Siblings_____

Children_____