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? ______________________________