



## HEALTH HISTORY

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ EMAIL: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

Health Condition	Do you have? Yes or No Describe
Diabetes—Type 1 or Type 2	
High Blood Pressure	
Heart Conditions/ Pacemaker	
HIV	
Cancer/ Chemotherapy	
Use of Blood Thinners (Coumadin or Warfarin)	
Skin (Sensitive, psoriasis, eczema, acne, etc)	
Is there any chance you could be pregnant?	___ Yes ___ No Date of last menstrual cycle: _____

Are you currently taking any *prescriptions* or *over the counter medications*? Please explain.

\_\_\_\_\_

Are you currently taking any *vitamins, minerals, or food supplements*? Please explain.

\_\_\_\_\_

What is your goal and/ or desired outcome? \_\_\_\_\_

\_\_\_\_\_

Is there anything you want our therapist to know as they work on you? \_\_\_\_\_

How many cups (8 ounces) of coffee do you drink/ day?	__0	__1	__2	__3 or more
How many sodas (8 ounces) do you drink/ day?	__0	__1	__2	__3 or more
How many glasses (8 ounces=1 cup) of water do you drink /day?	__8-16 ounces (1-2 cups)	__17-40 ounces (3-5 cups)	__40-63 ounces (5-7 cups)	__64 ounces or more (8+ cups)
How many alcoholic beverages do you drink/ week	__0	__1-3	__4-6	__7 or more

Would you like to be contacted by one of our Nutrition Professionals to further discuss your health goals, including weight loss, hormones, sleep, energy, digestion, skin, etc \_\_\_Yes \_\_\_No

**OVER**

