HEALTH HISTORY/INTAKE

Name:_________________________________ Birthdate: ______________ Date:_____/_____/______

Address _________________________________ **City, State, Zip** _________________________________

Email: __________________________**Phone (day):** ____________________**(evening):** ____________________

Billing address, if different:____

Best time to call: _____________________ **Preferred form of communication:** ___________________________

Weight: _______________ **Height:** ___________________ **Desired body weight:** ________________

GENERAL

Place of birth	Education
Relationship status	Occupation
Hobbies	Previous occupations
Exercise/recreation (types)	Height
Weight Weight 1 year ago Max Weight	
Date of last Physical Exam	Date of last Eye exam
Date of last colonoscopy	Date of last Prostate exam (men)
Date of last full bloodwork	Date of last Bone Density testing
Date of last Mammogram	Date of last Dental Exam

Stress level (1-10, with 10 highest) ____________ Energy level (1-10, with 10 highest) ______________

MEDICATION (**Please circle and date** everything you have taken or are taking: pills, tablets, liquids, ointments, suppositories, etc)

Antacids	Antibiotic/Antifungal	Antidepressants	Antidiabetic/Insulin
Aspirin/Tylenol	Chemotherapy	Cortisone	Anti-Inflammatories
Heart Medications	High Blood Pressure	Hormones	Laxatives
Lithium	Oral Contraceptives	Radiation	Recreational Drugs
Relaxants/Sleeping Pills	Thyroid	Ulcer Medication	Other

VITAMINS, MINERALS, HERBS, INCLUDE DOSES (Please list all you are taking now and for how long you have been taking them)

ALLERGIES:

Drugs:	
Foods:	
Environmental Sources:	
Other:	

CIRCLE IF YOU:

Diet often	Are under excessive stress	Are exposed to chemicals at work	Do not sleep well
Have a Eating Disorder	Use recreational Drugs	Spiritual Practice, please indicate →	

How many times per week **DO YOU DRINK OR CONSUME:**

Alcohol	Candy (other than dark chocolate)	Carbonated beverages (non-diet)	Cheese
Olive Oil	Vegetable oil (other than olive)	Lard or beef tallow	Dark chocolate (what %?______)
Whole wheat/grain bread or Brown rice	White bread/ white rice/potatoes without the skin/ crackers	Coffee (decaf)	Diet soft drinks
Raw veggies	Cooked Veggies	Corn chips/corn bread/corn tortillas	Yogurt, kefir, buttermilk
Sauerkraut, kim chee	Pastries, cinnamon rolls, doughnuts, etc.	Pizza	Hot dogs, bologna, etc
Cigarettes	Coffee (regular)	Meals at fast food restaurants	Fried foods
Luncheon meats	Margarine	Meat (Beef, pork, lamb, venison…)	Milk, cream or Ice Cream
Added sugar	Saccharine or Aspartame	Chew tobacco	Butter
Fresh/frozen fruit	Canned fruit	Fish or seafood	Eggs
Nuts (except peanuts)	Peanuts	Water (where from?__________)	Other?________________

How many times per week do you eat out? _________

Do you follow a medically prescribed diet? Y N If yes, what is it?

____

How often do you exercise and what type?____

How many hours of sleep do you get each night? _____ What are your constraints (if any)?

____

Do you wake up during the night? Y N If yes, how many times and at what time?

____

For good health, ***I think*** my body weight is . . . too high too low just right

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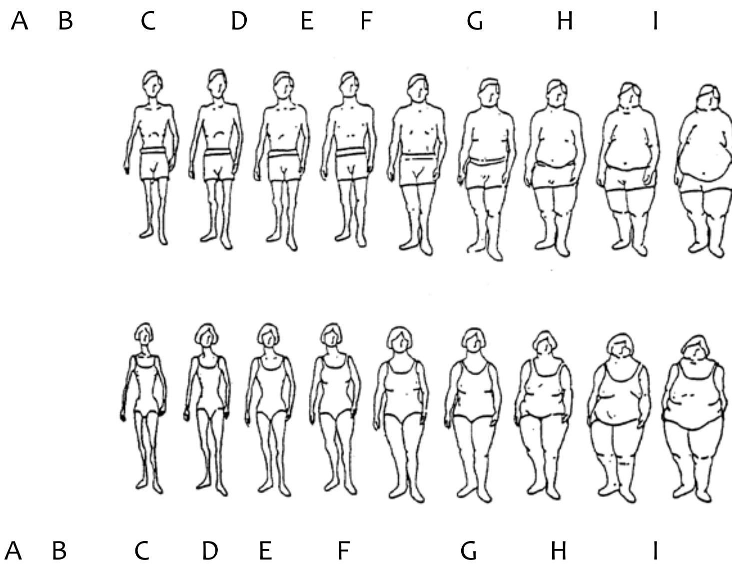
Has your Wt fluctuated up/down by more than 10 lbs in the past 6 mo, how much, when?

____

____

Which shape best corresponds to your current body shape (men top, women at bottom) (circle one):



Which shape best corresponds to the shape you would like to be? ________ (letter)

Which shape best corresponds to the shape you feel like you are? ________ (letter)

Which shape best corresponds to the shape you were at age 18 years? ________ (letter)

Which shape best corresponds to your mother's shape at age 35-45 years? ______(letter)

Which shape best corresponds to your father's shape at age 35-45 years? _______ (letter)

From - Eating Style, Habits, and Health Beliefs Questionnaire

DIET: *please list typical foods consumed on a regular basis*

Breakfast:____

Lunch: ____

Dinner: ____

Snacks: ____

Fluids: ____

Alcohol: ____

Diet

How much water do you drink a day?__________________________________

What kind of water do you drink?_____________________________________

How much coffee, tea, or soda do you drink per week?______________________

Do you have any dietary restrictions? (religious, vegetarian, allergies, etc?)________

____

How many times a week do you eat red meat?_____________________________

How many times a week do you eat fish?_________________________________

How many times a week do you eat fruit?_________________________________

How many times a week do you eat vegetables?____________________________

How many times a week do you eat dairy products?_________________________

Do you eat organic food? How often?____________________________________

How many times a week do you eat out at restaurants?_______________________

Do you eat smoked foods? How often?___________________________________

Do you often or have you recently traveled abroad? Where?___________________

____

PAST MEDICAL HISTORY

Measles	no	yes	Hives or Eczema	no	yes	chest x-ray	no	yes
Mumps	no	yes	Tuberculosis	no	yes	Infectious Mono	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Rheumatic Fever	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Mitral Valve Prolapse	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Stroke	no	yes
Diptheria	no	yes	Glaucoma	no	yes	Hepatitis	no	yes
Smallpox	no	yes	Hernia	no	yes	Thyroid Disease	no	yes
Blood Transfusions	no	yes	Kidney Disease	no	yes	AIDs or HIV+	no	yes
Heart Disease	no	yes	Bleeding tendency	no	yes	Anemia	no	yes

Venereal Disease (STD's) no yes

Exposure to environmental toxin no yes

Any other disease (please list)____

DIGESTIVE SYSTEM

Are you on a vegan diet (no animal products at all)?	Yes	No
Do you feel like belching, or are you bloated after eating?	Yes	No
Do you see undigested food or a greasy film in the toilet?	Yes	No
Do you lose weight easily or is it hard to gain weight?	Yes	No
Do you get heartburn/acid reflux? Times per week _________	Yes	No
Are your fingernails soft, brittle or have white spots?	Yes	No
Are you prone to muscle cramps? Which muscles? ___________	Yes	No
Do you have poor night vision?	Yes	No
Do you have or have you had an Ulcer?	Yes	No
Do you have or have you had gall bladder disease?	Yes	No
Do you have thyroid problems (that you know of)?	Yes	No (include all prior labs if you have been diagnosed)

FAMILY HISTORY (list by relation):

Alcohol or Drug Problem		HIV	
Allergies		Kidney Disease	
Anemia		Leukemia	
Ankylosing Spondilitis		Mental Illness	
Asthma		Migraine Headaches	
Autoimmune disorders		Multiple Sclerosis	
Cancer		Muscular Dystrophy	
Chronic Lung Disease		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Parkinson's disease	
Glaucoma		Rheumatoid Arthritis	
Gout		Stroke	
Heart Disease		Thyroid Disease	
Hepatitis		Tuberculosis	
High Blood Pressure		Ulcers	
High Cholesterol		Other	

REFERRAL INFO

Who can I thank for the referral?

____

____

At HartsSpace we offer multiple combinations of treatment. It is important to us, that we fully assess and understand the big picture and the whole body perspective on persons current needs.

What is/are the problem(s) in your own words?

How long has this been going on for (frequency, intensity, latency, recurrences, course, etc.):

____

____

____

____

How would life look different if this problem(s) were no longer an issue?

____

____

____

____

What interventions have you tried for this and other problems that you have had in your life? Were there any that you particularly found helpful or any that were not-helpful? (All people respond differently to treatments, it saves time and energy, for me to understand that which you have already learned about your health)

____

____

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