

1. What is your main physical complaint or health issue? ***What are your top 3 health goals?***

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1. What inherent (genetic) weaknesses run in your family’s history?
2. Please list all prescription medications, herbs, and supplements you are currently taking and reason for taking them.
3. Please list any known allergies (allergic reactions) to foods, medications or supplements (e.g. shellfish, dairy, eggs, etc.)
4. *Please check the box that best describes your health in regard to the following conditions.*
	* **Mental clarity** (Forgetfulness, brain fog)
	* No Problem
	* Low Concern
	* Moderate Concern
	* Serious problem

 **Stress Level** (Daily, work, life stress)

* + No Problem
	+ Low Concern
	+ Moderate Concern
	+ Serious Problem

 **Headaches**

* + No Problem
	+ Low Concern
	+ Moderate Concern
	+ Serious Problem

 **Backaches & Joint Pains**

* + No problem
	+ Low concern
	+ Moderate concern
	+ Serious problem

 **Anxiety**

* + No problem
	+ Low concern
	+ Moderate concern
	+ Serious problem

  **Depression**

* + No problem
	+ Low concern
	+ Moderate concern
	+ Serious problem

 **Immune System (Do you get sick easily?)**

* + No problem
	+ Low concern
	+ Moderate concern
	+ Serious problem

 **Sinus or lung infections/bronchitis**

* + No problem
	+ Low concern
	+ Moderate concern
	+ Serious problem
1. How many bowel movements are you having **each day?** Are they full and complete?
2. How is your energy throughout the day (high, average or low)?
3. Do you experience indigestion after meals? Sleepy after meals? Get bloated, gassy or have undigested food in stool?
4. Weight:

 Are you at your ideal weight?

 Underweight or overweight:

 What is your height?

 What is your weight?

 If overweight or underweight, by how much:

1. Describe the condition of your skin. Do you have normal skin or do you have problems with acne, wrinkles, dry skin, rashes or signs of premature aging?
2. Do you have any history of eating disorders such as anorexia, bulimia or over- consumption?
3. Sleep:

 How many hours of sleep do you get each night?

 Do you wake up feeling rested?

1. How much alcohol do you consume each day, week or month? Recreational marijuana or other drugs?
2. Do you use tobacco products? Yes\_\_\_ No\_\_\_

 If yes, what kind and how often?

1. How many times do you exercise each week? What is favorite way to get daily exercise? For how long each time?
2. Have you ever been exposed to harsh chemicals or fumes? Describe.
3. Have you had any surgeries or traumatic injuries, illnesses, or events? If yes, please explain.
4. Where do you purchase health related products and which supplements do you currently take daily (vitamins, herbs, teas etc.)?

19. Write everything you had to eat and drink over the last three days. Please include drinks and snacks, and estimate portion sizes (e.g., 3oz of chicken, 1 cup of rice, 16oz soda, 2 slices of pizza, 3 Tbsp nuts, etc.). PLEASE INCLUDE THE BRAND NAMES.

 **DAY 1:** Breakfast:

 Mid-morning snacks:

 Lunch:

 Dinner:

 Afternoon snacks:

 Dessert:

 Drinks and Ounces of water a day?

**DAY 2:** Breakfast:

 Mid-morning snacks:

 Lunch:

 Dinner:

 Afternoon snacks:

 Dessert:

 Drinks and Ounces of water a day?

**DAY 3** Breakfast:

 Mid-morning snacks:

 Lunch:

 Dinner:

 Afternoon snacks:

 Dessert:

 Drinks and Ounces of water a day?