



Please list any past / current prescription medications, over the counter medications, vitamins, herbs, homeopathics or other supplements you are taking, the dosage and how effective you have found these treatments:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

Approximately how many times in the last 5 years have you been treated with antibiotics? \_\_\_\_\_

Are you hypersensitive or allergic to any of the following (please list):

Drugs? \_\_\_\_\_

Foods? \_\_\_\_\_

Environmental? (e.g. pollen, dust, perfume) \_\_\_\_\_

\_\_\_\_\_

Have you had any specific allergy testing? If yes, please explain: \_\_\_\_\_

### MEDICAL HISTORY

List all surgeries you have had:

_____	year?	_____	purpose?	_____
_____	year?	_____	purpose?	_____
_____	year?	_____	purpose?	_____

Are there any traumatic events (surgeries, drug reactions, serious illness, accidents etc.) that you feel may have caused or contributed to your health problems?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Environmental Toxic Exposure

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium etc) while at work, home or travelling?      Y      N

Do you live near power lines or a refinery?      Y      N

Is your home and work environment well-ventilated?      Y      N

Do you smoke, or are you exposed to 2<sup>nd</sup> hand smoke?      Y      N

Do you have mercury dental fillings?      Y      N

Do you have any surgical implants (medical, cosmetic)?      Y      N

Do you have any body piercings?      Y      N

Has there been an event or sickness that you have never fully recovered from? Please indicate below

\_\_\_\_\_

**TYPICAL FOOD INTAKE**

Breakfast: \_\_\_\_\_  
 Lunch: \_\_\_\_\_  
 Dinner: \_\_\_\_\_  
 Snacks: \_\_\_\_\_  
 Beverages: \_\_\_\_\_  
 Cravings: \_\_\_\_\_  
 Aversions: \_\_\_\_\_

Do you add **salt** to your food?       Yes     No

How many **cups / day** do you drink of the following?

Pop \_\_\_ Fruit juice \_\_\_ Tea \_\_\_ Cow's Milk \_\_\_ Alcohol \_\_\_ Coffee \_\_\_

How many glasses of **water** do you drink per day?

Tap \_\_\_ Filtered \_\_\_ Distilled \_\_\_ Reverse Osmosis \_\_\_ Spring \_\_\_

What temperature of liquid do you prefer to drink? (circle)      hot      cold      room temp.

Do you have any dietary restrictions (religious, vegetarian, vegan etc.)?

\_\_\_\_\_

Are you satisfied with your diet the way that it is now? Why or why not?

\_\_\_\_\_

\_\_\_\_\_

**GENERAL**

Current Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood Type \_\_\_\_\_

Ideal Weight \_\_\_\_\_ As an adult what has your maximum \_\_\_\_\_ and minimum \_\_\_\_\_ weight been?

**FAMILY HISTORY**

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).

Allergies	_____	Eczema	_____
Anemia	_____	Heart Disease	_____
Asthma	_____	Juvenile Arthritis	_____
Autoimmune disease	_____	Kidney Disease	_____
Birth defects	_____	Mental illness	_____
Bleeding disorder	_____	Seizure/Epilepsy	_____
Cancer	_____	Stroke/Aneurysm	_____
Crohn's or colitis	_____	Thyroid condition	_____
Diabetes	_____	Tuberculosis	_____
Other	_____		

**SYMPTOM CHECKLIST**

Please take a moment to indicate the following symptoms or conditions you may have experienced either in the past, or presently.

**Symptom Checklist**

	<b>Past</b>	<b>Now</b>
Appetite change	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Black stools	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bleeding nose	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bruising	<input type="checkbox"/>	<input type="checkbox"/>
Chronic runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Gas / cramping	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Eczema / Hives	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Nights sweats	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

**Conditions**

	<b>Past</b>	<b>Now</b>
Acute epiglottitis	<input type="checkbox"/>	<input type="checkbox"/>
ADHD / ADD	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Congenital diseases	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis / Strep throat	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

**MENSTRUAL HISTORY**

Age at first menses: \_\_\_\_\_ Length of cycle in days: \_\_\_\_\_

Are you currently taking prescription birth control?  yes  no

If yes, what kind \_\_\_\_\_

Have you ever taken prescription birth control?  yes  no

If yes, what kind(s)? \_\_\_\_\_

For how long? \_\_\_\_\_

Do you cycle each month?  yes  noIf no, has it been longer than one year since your last cycle?  yes  noAre you cycles regularly spaced apart?  yes  no

Do you experience any of the following (please circle)?

Breast tenderness

Irritability

Acne

Bloating

Nausea/Vomiting

Low Libido

Mood Swings

Fatigue

Flu symptoms

Depression

Vaginal Dryness

Vaginal Discharge

Anxiety

Cravings

Spotting

Cramping

Hot Flashes

Infertility

Have you ever had a vaginal yeast infection?  yes  noIf yes, are these a chronic issue?  yes  noHave you ever had a urinary tract infection?  yes  noIf yes, are these a chronic issue?  yes  noHave you ever been diagnosed with an STD?  yes  no

# of pregnancies \_\_\_\_\_ vaginal birth or c-section?

# of miscarriages/ abortions \_\_\_\_\_

Any complications related to pregnancy/ childbirth?

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**LIFESTYLE PATTERNS**

What time do you go to bed? \_\_\_\_\_ Wake ? \_\_\_\_\_

Do you have trouble falling asleep? \_\_\_\_\_

Do you sleep through the night? \_\_\_\_\_

Do you wake up feeling refreshed? \_\_\_\_\_

Do you have any recurring dreams or nightmares? \_\_\_\_\_

What is your energy like during the day? \_\_\_\_\_

What is your current stress level? \_\_\_\_\_

Can you identify significant stressful periods in your life that you believe have impacted your health?

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Do you exercise? Yes No How often? \_\_\_\_\_ Type \_\_\_\_\_

What do you do to relax? \_\_\_\_\_

What are your hobbies / interests? \_\_\_\_\_

What are your health goals?

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Thank you for taking the time to fill out these forms.