

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 2nd 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

	Past	Now
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

	Past	Now
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"/>
Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

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?

Do you exercise? Yes No How often? _____ Type _____

What do you do to relax? _____

What are your hobbies / interests? _____

What are your health goals?

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