



Date: _____

Client Name: _____

Date of birth: _____

Address: _____

Email: _____

Phone: _____

Parent/Guardian name (if minor): _____

Parent/Guardian contact info (if different from above): _____

Occupation: _____

Primary Health Concerns:

1. _____

2. _____

3. _____

4. _____

FAMILY HEALTH HISTORY

Please list any major health issues for the following blood relatives of the client:

Alcohol/drug problem, Allergy/Asthma, Anemia, Arteriosclerosis, Arthritis, Binge Eating/Bulimia, Bleeding Problem, Cancer, Diabetes, Epilepsy/seizure, Heart disease, High blood pressure, High cholesterol, Kidney disease, Liver disease, Mental illness, Obesity, Stroke, Suicide, Thyroid disease, Tuberculosis, Ulcer, Syphilis, Skin disease, Gonorrhea, Other

Paternal Grandfather	Paternal Grandmother	Father	Mother	Maternal Grandfather	Maternal Grandmother

HISTORY OF CLIENT ILLNESS, INJURY, AND MEDICAL PROCEDURES:

Hospitalizations: Reasons and Dates

Surgeries: Procedures & Approximate Dates

Serious Illnesses:

Accidents / Traumatic Injuries / Broken Bones:



Current Medical Diagnoses, if any:

CURRENT MEDICATIONS / SUPPLEMENTS STARTED	TREATMENT FOR	YEAR / DATE

HEALTH CONDITIONS

Please check off all that apply to you and list approximate dates/ years.

- | | |
|---|---|
| ☐ Acne _____ | ☐ Eczema _____ |
| ☐ AIDS _____ | ☐ Endometriosis _____ |
| ☐ Alcohol / Drug Problem _____ | ☐ Fibroids (Uterine) _____ |
| ☐ Allergies _____ | ☐ Gallbladder _____ |
| ☐ Anemia _____ | ☐ Glaucoma _____ |
| ☐ Antibiotics (>= 1x a year) _____ | ☐ Gout _____ |
| ☐ Anorexia / Bulimia _____ | ☐ Hearing Problems _____ |
| ☐ Anxiety _____ | ☐ Heart Attack _____ |
| ☐ Arthritis _____ | ☐ Heart Failure _____ |
| ☐ Back problems _____ | ☐ Hemorrhoids _____ |
| ☐ Binge Eating _____ | ☐ Hepatitis _____ |
| ☐ Bladder Infections _____ | ☐ Herpes _____ |
| ☐ Blood Clots _____ | ☐ Hernia _____ |
| ☐ Bronchitis _____ | ☐ High Blood Pressure _____ |
| ☐ Cancer _____ | ☐ High Cholesterol _____ |
| ☐ Cataract(s) _____ | ☐ Hives _____ |
| ☐ Chemical Sensitivity _____ | ☐ Insomnia _____ |
| ☐ Chronic Fatigue _____ | ☐ Kidney Infections / Stones _____ |
| ☐ Colitis _____ | ☐ Liver Disease _____ |
| ☐ Depression / Anxiety _____ | ☐ Menstrual Problems _____ |
| ☐ Diabetes _____ | ☐ Mental Illness _____ |
| ☐ Ear Infections _____ | ☐ Migraines _____ |

- | | |
|---|--|
| ☐ Mononucleosis _____ | ☐ Sexually Transmitted Infections _____ |
| ☐ Mumps _____ | ☐ Sinusitis _____ |
| ☐ Neurological Problems _____ | ☐ Sleep Disorder _____ |
| ☐ Nightmares / Night Terrors _____ | ☐ Steroid Use _____ |
| ☐ Overweight _____ | ☐ Stroke _____ |
| ☐ Panic Attacks _____ | ☐ Suicide Attempt _____ |
| ☐ Pelvic Infection _____ | ☐ Syphilis _____ |
| ☐ Periodontal Disease _____ | ☐ Thyroid Problems _____ |
| ☐ Phlebitis _____ | ☐ Tuberculosis _____ |
| ☐ Pneumonia _____ | ☐ Ulcer _____ |
| ☐ Premenstrual Problems _____ | ☐ Vaccine Reaction _____ |
| ☐ Psychotherapy _____ | ☐ Warts _____ |
| ☐ Rheumatic Fever _____ | |
| ☐ Scarlet Fever _____ | |
| ☐ Seizures / Epilepsy _____ | |

Additional note space (if needed):

LIFESTYLE

Allergies	Food Allergies (include method of testing)
Food Cravings	Alcohol / Recreational Drug Use – Do you drink alcohol or use drugs? How much / often?
Caffeine – Do you drink coffee or tea? How much / often?	Do you smoke now or did you in the past? How much / often?
Diet Soda / Artificial Sweeteners – Describe your use	Refined Sugars / Processed Foods – Describe your use
Hobbies – List any. How often do you do them?	Living Situation
Exercise – Describe the ways you get your body moving. Do you feel you get enough physical activity?	Food – Do you feel you eat a healthy and well-balanced diet? Do you need guidance / support?
Worry / Anxiety – Do you have particular issues that worry you? How does this impact your life?	Healthy Relationships - Do you have a supportive family / community?

Unhealthy Relationships – Have you been a victim of domestic abuse or troubling relationships?

Intimacy – Are you satisfied with your sexual / intimate life?

Anything else? Please indicate any other topics you want to address in your consultation.

LIFE CHANGES - In the past year, what changes have occurred in your:

Personal Life:

Family Life:

Social Life:

Work Life:

Any other changes: