Health History

Name: _____

Address: _____

E-mail: _____

Telephone Home: _____ Work: _____ Mobile: _____

Date of Birth: _____ Place of Birth: _____

Primary Physician: _____ Telephone: _____

Where were you raised? _____ Health as a child? _____

Do you know anything about your mother's pregnancy or your infancy? _____

Were you breast-fed? _____

How is the health of your mother? Death/Cause: _____

How is the health of your father? Death/Cause: _____

Health of siblings, if any? _____

Serious illness/hospitalizations/injuries (provide dates): _____

What is your chief concern? _____

Other concerns? _____

Height: ____ Weight: ____ Weight six months ago: ____ One year ago: _____

Would you like your weight to be different? ____ If so, what? _____

Relationship Status: _____ Children (number & ages):_____

Occupation: _____ Hours of work per week:_____

Frequency and duration of work related travel: _____

On a scale of 1-10, rate how stressful your life is today _____ 1 yr ago ___ 5 yrs ago ____

Do you sleep well? _____ Do you wake up at night? _____ What times?_____

To urinate? _____ Other? _____ What time do you generally get up in the morning? _____

Are there times during the day that your energy is low? _____

Constipation/Diarrhea? _____ Do you know what blood type you are? _____

Women: Are your periods regular? ____ How many days is your flow? _____

How frequent? _____ Painful or symptomatic? _____

List any vitamins or medications you are taking: _____

_____

When was the last time you took antibiotics? _____ For what illness? _____

Do you have any food allergies or sensitivities? _____

Do you have environmental or seasonal sensitivities? _____

Are there any healers, helpers or therapies with which you are involved? _____

_____

Do you exercise? _____

Coffee (times/day): _____ Cigarettes? _____ Alcohol? _____

Which meals for you are home cooked and how frequently? _____

Where do you get the rest of your meals from? _____

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Is cooking for yourself/your family enjoyable or a task? (circle one)

What are the food staples that are in your kitchen pantry? _____

What are the food staples that are in your fridge/freezer? _____

_____

List 3 foods you absolutely cannot live without: _____

Are there any foods you absolutely detest? _____

Recurrent cravings? How often & when? _____

What foods did you eat often as a child?

Breakfast		Lunch		Dinner		Snacks		Liquids

What foods do you eat currently?

Breakfast		Lunch		Dinner		Snacks		Liquids

What were you eating one year ago?

Breakfast		Lunch		Dinner		Snacks		Liquids

Is there anything else I need to know? _____

Whom can I thank for referring you to me? _____

I understand that this consultation is a wellness consultation, which includes evaluating the eating habits and nutrition, exercise, emotional wellbeing, and may include recommendations for other healing modalities as necessary. I also understand that this consultation is informational and for educational purposes only. It is not intended to diagnose or cure any ailment or disease. I am fully responsible for how I apply the information received.

_____ _____

Signature Date

Natasha Zarrin, H.H.C.