Health History Form

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Age:_____ Birthdate:_____

Email: _____

Phone: Cell: _____ Home: _____

In case of emergency, contact: _____ Phone: _____

SOCIAL INFORMATION

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____ Number of children: _____

Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel:

_____

_____

_____

Occupation: _____ Place of work: _____

Hours of work per week: _____

HEALTH INFORMATION

Height:_____ Current weight:_____

Body type you identify with (circle):
underweight, lean, healthy, average, athletic, curvy, overweight, not healthy

Has your weight changed or maintained the same throughout adulthood?

How do you feel about your current physical self (circle):
I'm happy with my body, I'd like to make small adjustments, I'd like to make big changes

How would you describe your relationship with food or eating habits?

What current health concerns and/or goals do you have?

Do you have any current major stresses in your life? If so, what are they?

How do you handle stress? Relaxation techniques?

Do you sleep well? _____

How many hours of sleep do you get per night? _____

When in your life have you felt your best?

MEDICAL INFORMATION

Please list any major surgeries or illnesses:

Please list any supplements or medications you are currently taking?

Allergies or sensitivities? Please explain:

Digestive issues? Please explain:

Are you currently under the care of a medical doctor? If yes, please list:

Are you seeing any other type of health care provider or therapist? If yes, please list:

What is your current activity level?

What type of exercises or sports do you participate in?

FAMILY HISTORY

Did or does your mother have any serious illnesses/hospitalization/injuries?

Did or does your father have any serious illnesses/hospitalizations/injuries?

Did or does any other immediate family member have a serious illness/hospitalization/injury?

DIETARY INFORMATION

How would you rate your diet? ____Good _____Fair _____Poor

What foods do you eat for breakfast/lunch/dinner?

What liquids do you drink during the day?

What percentage of your food is home cooked? Do you cook?

How many times a week do you eat the following meals away from home?

_____ Breakfast _____ Lunch _____ Dinner

What types of eating places do you frequent?

____Fast food ____ Diner/Cafeteria ____ Restaurant ____ Other

How many meals do you eat per day?

How many snacks do you eat per day?

Are you addicted to any of the following? Tobacco, sugar, caffeine, alcohol

How does your spouse, partner, family, friends, and significant others feel about your health concerns?

Is your spouse, partner, family, friends and significant others supportive of you changing your diet and/or lifestyle?

ADDITIONAL COMMENTS

Are there any other important facts about you and/or your health that you would like me to be aware of?