HEALTH HISTORY FORM

(Please fill out thoroughly and print clearly)

Name: _____Date: _____ Age: _____

Male/female: _____ Height: _____ Weight: _____ Weight one year ago: _____

Would you like your weight different? _____If so, what? _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Country: _____

Email: _____

Home Phone: _____ Cell Phone: _____

What is your occupation? _____

Do you consider your work stressful? _____ Hours of work per week? _____

Do you have children you are raising? _____ If so, what ages? _____

Are you married or live with a partner? _____

Do you have his/her emotional support and understanding with your health issues/symptoms?

Yes, no or somewhat?: _____

Do you have your parent's, other family member or a close friend's emotional support? _____

Do you have family or friends available that can help assist you with cooking meals, grocery shopping and other house hold duties? _____

Do you sleep well (yes or no) ? _____ Do you wake up at night? _____

If so, is it because you need to urinate? _____If applicable, how many times do you usually wake up each night? _____

What time(s) usually? _____

What time do you usually get up in the morning? _____ What time do you usually go to sleep at night? _____ How long does it usually take you to fall asleep? _____

Do you usually have at least 1 full bowel movement daily?

_____

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

Did your mother have amalgam fillings when she was pregnant with you? _____

Did you have infant/childhood vaccinations? _____

Have you ever had vaccinations of any kind as an adult? _____

If so, what kind and when? _____

_____

Do you presently have any amalgam silver colored fillings? _____ If so, how many? _____

Did you ever used to have amalgam fillings? _____

If so, how many did you get as a child? _____How many did you get as an adult? _____

When did you have them removed? _____

Do you have any gold in your teeth? _____ Do you have any root canals? How many? _____

Do you presently eat any seafood (fish or shell fish)? _____

Did you used to eat more seafood than now? If so, please explain: _____

_____

Do you have any tattoos? _____

When did you start becoming symptomatic (having symptoms)? _____

What symptoms did you initially start developing? _____

_____

Did you become symptomatic soon after you had a flu shot or other vaccination? If so, please explain:

_____

_____

Did you become symptomatic after getting any amalgam fillings removed? _____

Did you become symptomatic after getting a root canal? _____

Have you ever had DMPS orally or intravenously? _____

If so, please explain how you tolerated the treatment: _____

_____

_____

Have you ever taken DMSA? _____If so, what dose(s), when and how did you handle the treatment? _____

_____

Do you drink coffee? _____ How much? _____ Do you smoke cigarettes? _____

Do you drink alcohol? _____How many drinks weekly? _____

What percentage of your food is home cooked? _____

Where do you get the rest of your food from?

_____

Any past serious illnesses/hospital stays/injuries? _____

_____

_____

_____

Do you have your tonsils? _____ Do you have your gall bladder? _____

Have you had any other organs or glands surgically removed? _____

_____

When do you usually feel your worst? Mornings: _____ Afternoon: _____ Evenings: _____N/A: _____

Name your top 5 worst symptoms:

1)_____

2)_____

3)_____

4) _____

5)_____

Please put a number next to each symptom listed below that applies to you.

0=none, 1=very mild, 2-3=mild, 4-5=moderate, 6-7=moderate to severe, 8-10=severe

(explain further if desired)

Anxiety: _____

Insomnia: _____

Depression: _____

Emotional instability/unpredictable mood swings (ups and downs): _____

Emotionally sensitive (cry/anger/upset easily) _____

Compulsive thinking/busy mind: _____

Obsessive/irrational fear:

_____

Developing Phobias: (fear of being in a small room, leaving home, the dark, being alone, fear of dying, etc.)

_____

Feel abnormally stressed or insecure in public or social settings: _____

Feel abnormally reclusive: _____

Chronic Fatigue: _____

Headaches or head pressure: _____

Brain fog/poor focus and concentration: _____

Poor memory: _____

Dizziness: _____

Vertigo: _____

Tinnitus (buzzing or ringing in ear): _____

TMJ/jaw pain: _____

Bodily nerve twinges: _____ Twinges near eyes? _____

Bodily aches and pains: _____ Joint pain: _____

Muscle cramps (charlie horses): _____

If so, how many times weekly? _____ What location(s)? _____

Feel surreal (not in reality): _____

Scary involuntary mental flashes of images/pictures: _____

Stomach pain or discomfort: _____

Abdominal bloating/gas: _____

Distended/swollen abdomen: _____

Have you ever seen worms/parasites in your stool? _____

Stomach pain/discomfort after eating meals: _____

Heaviness/lethargy after meals: _____

Constipation: _____ Diarrhea: _____ Both (alternates): _____

Burning skin: _____ If so, what location(s)? _____

Itchy skin: _____If so, what location? _____

Panic Attacks: _____

Heart Palpitations: _____

Feeling oxygen deprived (like there's not enough oxygen in your air): _____

Abnormal hair loss: _____

Weak appetite: _____

Sensitivities to foods/food allergies: _____

If so, what foods do you suspect you are sensitive/allergic to? _____

_____

If so, what herbs/nutraceuticals/supplements have you taken in the past you suspect caused a sensitivity or problem?

_____

_____

Sensitive to chemicals (perfume, cleaners, alcohol intolerant, etc.): _____

Sensitive to electromagnetic frequencies (EMF's), being at computer, using cell phone, etc: _____

Sensitive to bright light: _____

Sensitive to normal sounds/noise: _____

Chronic infections (bladder, sinus, lung, vaginal/prostate, throat, etc.): _____

Frequent urination: _____

Please list any other symptoms or concerns not listed: _____

_____

WHAT FOODS DO YOU NORMALLY EAT?

Breakfast

1. _____

2. _____

3. _____

4. _____

5. _____

Lunch

1. _____

2. _____

3. _____

4. _____

5. _____

Dinner

1. _____

2. _____

3. _____

4. _____

5. _____

Snacks

1. _____

2. _____

3. _____

4. _____

When do you usually eat breakfast? _____

When do you usually eat lunch? _____

When do you usually eat dinner? _____

When do you usually snack? _____

Please list all medications you are taking and why:

1. _____

Why? _____

2. _____

Why? _____

3. _____

Why? _____

4. _____

Why? _____

5. _____

Why? _____

6. _____

Why? _____

7. _____

Why? _____

Please list all herbal formulas/nutraceuticals/supplements/homeopathics you are taking:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

16. _____

17. _____

18. _____

19. _____

20. _____

Please list any other healing/detoxing modalities, therapies or treatments you are presently doing (i.e. infrared sauna, acupuncture, chiropractic, craniosacral therapy, massage, colonics, rectal suppositories, etc.)

_____

_____

_____

_____

How did you hear about us?

Google Search _____

Yahoo Search _____

Facebook _____

My Story Online _____

Support Group _____

Referral (who may we thank?) _____

List the full name of any person(s) you approve to discuss your health or your personalized program with (i.e. doctor, family member, spouse, friend):

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

4. _____ Relationship: _____

5. _____ Relationship: _____

Client Signature: _____ Date: _____