New Patient Health History Form

Welcome to your wellness program! I'm thrilled to be working with you. Please take some time to answer the following questions and return the packet to me **before our first call.** All answers in this questionnaire are confidential and will become part of your medical record.

Name: (Last, First)
☐ M ☐ F DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Contact Phone:
Address:
Email:
Occupation:
Hours of work per week:
Do you have children? If so how many and what ages:
Do you have any pets:

Basic Health

Height:	Weight:
The most important thing(s) I want to achieve to improve my health is:	
What strategies have you tried to address your concerns?:	

List any medicine you are currently taking:
List any vitamins, minerals, herbs and nutritional supplements you are taking:
List any allergies to medication and reaction you had:
Are you seeing or have you seen any medical doctors, chiropractors, or therapists for your current concerns?:
On average, how many times per week have you exercised in the last 6 months? ☐ 7 days ☐ 3 to 5 days ☐ 1 to 2 days ☐ I don't really exercise
What kind of exercise do you mainly do? You can mark more than one. ☐ Aerobic (walking/jogging) ☐ CrossFit/HIIT ☐ Sports (basketball, soccer, volleyball, ect.) ☐ Weights ☐ Yoga, Pilates or Tai Chi

History

Have you or your family recently experienced any major life changes? If so, please comment.
Have you experienced any major losses in life? If so, please comment.

How many days have your taken off work or school in the last year due to sickness?

Sleep Habits

Do you sleep through the night? □ Y □ N
How many hours of sleep do you get per night?
Do you wake up in the middle of the night or have trouble falling sleeping? □ Y □ N
If yes, why?

Medical

What are your main health concerns?
When did you first experience these concerns?
How have you dealt with these concerns in the past?
Have you experienced any success with these approaches?

Please list the date and description of any medical condition you have or have had, such as:

	Date	Description
Allergies		
Arthritis		
Asthma		
Cancer		
Chronic yeast infections		
Depression		
Diabetes		
Heart disease		
Hepatitis		
High blood pressure		
High cholesterol		
Kidney disease		
Stroke		
Thyroid disease		

Please list the date and description of any surgical procedure you have had:

Family Medical History

How is/was your mother's health?

How is/was your father's health?

Women's Health

Are your periods regular? □ Yes □ No □ N/A
How many days is your period?:
Painful or symptomatic? Please explain:
Have you had any problems with conception or pregnancy?:
Birth control history? Please explain:
Do you experience urinary tract infections or yeast infections?: □ Y □ N
Are you approaching or have you reached menopause?: □ Y □ N
Are you taking any hormone replacement therapy or supportive herbs? If so, please list here.

Mental Health Status

How are your moods in general? Do you experience more anxiety than you would like? Depression? Anger?

On a scale of 1-10, with one being worst and 10 being best, describe your usual level of energy.
At what point in your life did you feel best? Why?
How do you handle stress?
Have you ever struggled with an eating disorder?

Nutritional Status

Do you cook? □ Y □ N
What percentage of your food is home cooked?
Where does the rest of your food come from?
Which of the following foods do you consume regularly? □ Corn □ Dairy (i.e milk, cheese, yogurt) □ Fast Food □ Gluten (i.e. wheat, rye, barley) □ Refined Sugar
List any foods that you avoid because of the way they make you feel. Please name the food and the symptom.

Do you have symptoms immediately after eating—like bloating, gas, sneezing, or hives? If so, please explain.
Are you aware of any delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? If so, please explain.
Describe your diet at the onset of any health concern you currently have.
List any special diet you are currently on
How much water do you drink per day? A standard glass is 8 cups or 8 ounces □ 8 glasses □ 6 to 7 glasses □ 4 to 5 glasses □ 1 to 3 glasses □ I don't drink water daily
Caffeine: □ None □ Coffee □ Tea □ Soda # of cups/cans per day?: _____
Do you drink alcohol? □ Y □ N If yes, how many drinks per week?: _____
Have you used or abused alcohol, drugs, meds, tobacco, or caffeine? □ Y □ N Do you still?
Is there anything else I should know about your current diet, history or relationship to food?

Will your family and/or friends support you in your healthy changes?

Other Problems

Check if you have, or have had, any symptoms in the following areas and briefly explain. ☐ Back ☐ Bladder/Bowel ☐ Chest/Heart ☐ Circulation ☐ Ears ☐ Head/Neck ☐ Intestinal ☐ Lungs ☐ Nose ☐ Skin ☐ Throat
☐ Recent Changes in: ☐ Ability to sleep ☐ Energy level ☐ Weight ☐ Other pain/discomfort
On a scale of 1-10 with 10 being the best and zero being the worst, how would you rate the following: Brain Function - Focus/Memory: _____ Energy: _____ Fitness: _____ Nutrition: _____ Peace (vs Stress): _____ Relationships: _____ Sleep: _____

Thank you, we look forward to speaking with you shortly!