CLIENT HEALTH HISTORY

All information remains strictly confidential

Name _____ Date _____
Address _____
City _____ Prov _____ Postal Code ____
Home Phone _____ Work Phone _____
Date of Birth _____ Sex _____
Family Physician _____
Occupation
Are you taking any medications? Please list _____

Do you use over the counter medications? Please list _____

Do you have any known food, environmental, animal or drug allergies? Please list _____

Are you taking any vitamins or other food supplements? Please list _____

Please list any illnesses with which you have been diagnosed _____

Do you exercise regularly? Explain _____

What are your main health concerns? _____

Are you currently seeing other health practitioners such as chiropractor, massage therapist, reflexologist, homeopath, naturopath, etc? _____

Please list any surgeries, with dates _____

Please list any accidents _____

Do you have a family history of any of the following? _____
Allergies _____ Diabetes _____
Cancer _____ Heart/Circulation Problems _____
Depression _____ Osteoporosis _____
How many bowel movements do you have daily? _____
Please list any bowel problems you've had _____

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Do you smoke?_____Have you ever smoked?_____If so, when did you quit?____
How many mercury amalgam fillings do you have? _____
If none, have you had some removed?_____When?_____
Have you had dental problems?_____
_____
Have you had recent antibiotic treatment? When & For what_____
_____
Have you had Candida (yeast infections)? _____
Other fungal infections?_____
_____
Do you get colds or flu's often? _____
Did you have a childhood history of infections (ear, sinus, throat, urinary tract, kidney, etc)?
_____
_____
List any toxic environmental substances you've been exposed to_____
_____
_____

DIET

Are you on a special diet?_____
_____
Do any foods bother you?_____
_____
How much of the following do you drink each day?_____
Alcohol_____Coffee_____
Fruit juices_____Milk_____
Tea_____Soft drinks_____
Water_____Spring_____Distilled_____Reverse osmosis____Well_____City___
How often you do: eat in restaurants?_____Eat raw foods_____
Do you feel tired or sleepy after meals?_____
Any symptoms if you skip meals?_____
_____
How often do you eat bread, what kinds?_____
How often do you eat pasta, what kinds?_____

24 HOUR DIETARY RECALL

Breakfast_____Lunch _____
_____ _____
_____ _____
Supper_____ Snacks _____
_____
Is there anything you have experienced after which your health has never been the same?
_____
_____
_____