

HEALTH HISTORY FORM

PERSONAL INFORMATION

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| --- | --- | --- | --- |
| First Name: |  | Last Name: |  |

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| Email: |  | How often do you check email? |  |

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| Home Phone: |  | Work Phone: |  | Mobile phone: |  |

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| Do you text? |  | Skype address: |  |

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| Home Address: |  |

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| Age: |  | Birth date: |  | Place of Birth: |  |

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| Where do you currently live? |  |

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| Relationship status: |  |

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| Children: |  | Pets: |  |

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| Occupation: |  | Hours of work per week: |  |

CONCERNS

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| Please list your main health concerns: |  |
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| Other concerns? |  |
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MEDICAL INFORMATION

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| Height: |  | Current weight: |  | Weight six  Months ago: |  | One year ago: |  |

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

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| Have you been diagnosed with any medical conditions or “Pre” conditions? | |  | |
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FAMILY HISTORY

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| How is/was your mothers’ health? |  |

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| How is/was your father’s health? |  |

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| Family history of heart disease, hypertension, cancer, diabetes or dementia? |  |
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LIFESTYLE INFORMATION

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| How is your sleep? |  | How many hours? |  | Do you wake up at night? |  |

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| Why? |  |

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| What do you do for physical activity and how often? |  |
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| Do you currently have any major stressors in your life? |  |
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| What do you do when you feel stressed? |  | |
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| Do you have any addictions (cigarettes, alcohol, sugar, coffee, drugs, other)? | |  |  |
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| Do you have satisfying relationships on your life? |  |
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| What do you do for fun? |  |

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| At what point in your life did you feel best? |  |

FOOD INFORMATION

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| What is your food on typical days? |

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| Breakfast | |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
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| Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? |  |

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

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| Where do you get the rest from? |  |

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| Do you crave sugar, coffee or other foods? |  |

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| The most important thing I should change about my diet to improve my health is: |  |
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GOALS:

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| Please list your main health goals: | |  |
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| Other goals: |  | |
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| What have been your biggest blocks to reaching your goals? |  |
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| What do you think you really need to reach your goals? |  | |
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ADDITIONAL COMMENTS

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| Anything else you would like to share? |  |
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Adapted from the Institute for Integrative Nutrition Health History