HEALTH HISTORY QUESTIONNAIRE

Please complete this form to the best of your ability, as your answers will be a great asset in helping me assist you during our session. You do not need to answer every question if you do not want to. All information is kept strictly confidential.

Name: *(Last, First):* ☐ M ☐ F	**Birthday (D/M/Y):**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Are you living with: ☐ Alone ☐ Spouse ☐ Partner ☐ Children ☐ Spouse and children ☐ Parents ☐ Roommate	**Do you have children? If so, how many?** ☐ 1 ☐ 2 ☐ 3 ☐ 4+
Occupation:	
Address:	**Province/State, Country:**
Telephone number:	**Are you willing to receive text messages?** ☐ Yes ☐ No

GENERAL HEALTH INFORMATION

Blood type: ☐ A ☐ B ☐ AB ☐ O ☐ I don't know

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Anxiety/chronic worrying	☐ Anemia	☐ Arthritis
☐ Brain fog/memory decline	☐ Constipation	☐ Depression
☐ Easy bruising/bleeding	☐ Enlarged lymph nodes	☐ Fatigue
☐ Frequent infections/illnesses	☐ Gallstones	☐ Gas/bloating/indigestion
☐ Heart palpitations/irregular heartbeat	☐ High blood pressure	☐ High cholesterol
☐ Insomnia	☐ Intestinal disorders (IBS, Chron's, Colitis)	☐ Joint pains
☐ Liver/gallbladder conditions	☐ Lung/respiratory conditions	☐ Osteoporosis
☐ Overweight	☐ Swelling of extremities	☐ Other pain/discomfort:
☐ Thyroid conditions	☐ Unexplained pains	

On a scale of 1-10, what would you consider your overall state of health at this time? 1=Poor health 10=Excellent health

Poor ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Excellent

Please list your main health concerns (physical, emotional, psychological) in order of importance to you. When did you start experiencing these symptoms?

What do you believe is the main cause of your health concern(s)?

What behaviors or lifestyle habits do you engage in regularly that you believe are supportive to your health and wellbeing?

What behaviors or lifestyle habits do you engage in regularly that you believe are NOT supportive to your health and wellbeing?

What stands in the way of your ability to make healthy lifestyle choices? (For example, living with a spouse who does not support a healthy lifestyle)

What are your top 3 issues that you would like to work on? It's important to set goals so we know what to focus on.

1.

2.

3.

DIETARY AND LIFESTYLE HABITS

Diet

Are you dieting?	☐ Yes	☐ No
Are you following a special diet or nutritional program?	☐ Yes	☐ No

If so, what kind of diet? (i.e., vegan, gluten-free, dairy-free, low carb)

	Breakfast	Lunch	Dinner
Give examples of your typical meals:			

How often do you eat meat? ☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ 4-5x a week ☐ 3x a week or less

Do you consume any of the following on a daily basis: ☐ Dairy products (milk/cheese/yoghurt) ☐ Wheat (bread, pasta) ☐ Refined sugar

What foods do you crave the most? (Including junk foods)

What are the top 5 foods you eat most frequently?

1.
2.
3.
4.
5.

What foods do you choose not to eat and why?

Are you willing to replace unhealthy food choices with healthier options? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No What percentage of your meals are home-cooked? ☐ none ☐ 1 meal ☐ 2 meals ☐ all meals

When you don't cook, what do you like to eat out?

Check the following factors that apply to your eating habits:

☐ Fast eater	☐ Don't eat sitting at a table	☐ Binge eating/food addiction
☐ Erratic eating pattern	☐ Late night eating	☐ Time constraints
☐ Eat while multitasking	☐ Non-availability of healthy/fresh foods	☐ Significant others don't like healthy
☐ Do not plan meals or cook	☐ Prefer convenience	☐ Poor snack choices
☐ Confused about nutrition advice	☐ Don't see the relationship between diet and health/wellbeing	☐ Significant others don't eat healthy

Which of these would you like to change the most?

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit			

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

MEDICAL HISTORY

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Antibiotic Usage

Year	Reason	Duration

List your prescribed drugs / over-the-counter drugs and supplements

Drug/Supplement	Strength	Frequency Taken

Do you have mercury fillings (dental)? ☐ **Yes** ☐ **No**

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		