lear For lear For

SUMMARY OF HEALTH HISTORY

DATE: _____

CLIENT'S CONTACT INFORMATION

NAME:					
ADDRESS:					
CITY:		STATE:		ZIP:	
BIRTHDAY:		AGE:		SEX:	
HOME NUMBER:		WORK NUMBER:			
CELL PHONE:		EMAIL ADDRESS:			
REFERRED BY:					

GENERAL INFORMATION PLEASE COMPLETE THE FOLLOWING INFORMATION. PUT A CHECK NEXT TO ALL THAT APPLY TO YOU AND INCLUDE THE APPROXIMATE AGE OF OCCURRENCE.	START AGE	END AGE
☐ Smoker		
☐ Recreational Drugs		
☐ Alcohol Number of glasses: Per: ☐ Day or ☐ Week		
☐ Coffee Number of cups per day:		
☐ Soft Drinks Number of glasses per day:		
☐ Women: Breast Implants		
☐ Cancer		
☐ Headaches		
☐ Other:		
☐ Other:		

DIET

DESCRIBE YOUR DIET & APPETITE BELOW.

Serious Infections/Diseases Such as: Pneumonia, Mono, TB, Heart Attack, Colitis, Chronic Allergies, Chronic Strep, etc.	**Age**

Surgeries List the type of surgery you have had.	**Age**

Dental Intervention	**Quantity**	**Age**
Root Canals		
Crowns/Caps		
Silver Fillings		
Gold Fillings		
Removal of Mercury		
Braces		
TMJ		

Water Intake

Number of 8oz. glasses you drink per day:	
Type of water you drink:	

PREGNANCIES/BIRTHS/ABORTIONS/IUD/BIRTH CONTROL PILLS (PLEASE LIST)	AGE

IS YOUR CYCLE REGULAR? ☐ **YES** ☐ **NO**

IF NOT, PLEASE EXPLAIN.

it just returned 2 years and a few months post-partum

DIGESTIVE HEALTH

How many bowel movements per day?	
Is elimination complete?	☐ Yes ☐ No
Describe consistency (watery, loose, hard, etc.)	

PRESCRIPTION DRUGS	AGE

TOXIC EXPOSURES (PAST OR PRESENT)

SUCH AS: PESTICIDE, ASBESTOS, PRINTING INDUSTRY, DENTIST, ARTIST, FUEL INDUSTRY, PAINTER, HIGH EMF, ETC.

Emotional Stress Such as: anxiety/depression	**Age**

Sleep Habits Such as: Insomnia, etc. Please describe below	**Age**

Foreign Travel Especially third world countries.	**Age**

Allergy Symptoms	**Severe**	**Moderate**	**Mild**
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Injuries/Accidents With or without stitches, include head trauma.	**Age**

Medications And/Or Supplements

Please list any medications and/or supplements you are currently taking.

Health Concerns

Please list all health concerns.

Additional Information

Please list any additional information you would like me to know about.