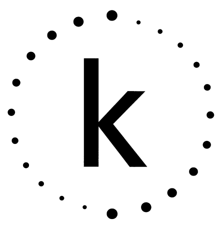


PERSONAL HEALTH HISTORY

Date: ____________

I. GENERAL INFORMATION

Name____ Phone (   ) ______________________

Address _______________________________________ DOB ( ) _________________________

City, State, Zip __________________________________ Birthplace______________________

Work/Occupation____

Address____

Approximate date of last medical exam____

Are you presently under a Doctor's Care ____

Do you currently take any medications? ______ If so, which? ____________________________

Rx____

How Rx____

Are there any other healers, helpers or therapies with which you are involved? ______________

Who and/or what? ____

How long? ____

II. FOCUS

1.) What is your chief concern?

____

____

____

2.) What are your goals for your health/life?

____

____

____

3.) List any other current symptoms or problems?

____

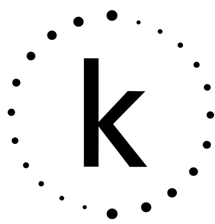
____

____

4.) What are the three factors in your life that seem the most important to your daily life? -

____

____



5.) Any major illnesses or hospitalizations? What and when?

____

____

____

Of the following check any that you have incurred. Write approximate year in the space provided.

____Pneumonia	____high Blood Pressure	____Kidney Infection
____TB	____Low Blood Pressure	____Parasites
____Hepatitis	____Heart Disease	____Rheumatic Fever
____Asthma	____Heart Attack	____Measles Reg.
____Diabetes	____Cancer	____Measles Germ.
____Hypoglycemia	____Blood Transfusion	____Mumps
____Epilepsy	____Migraine Headache	____Chicken Pox
____Eczema	____Ulcer	____Polio
____Skin Boils	____Anemia	____Whooping Cough
____Kidney Stones	____Arthritis	____Diphtheria
____Drug Reactions	____Obesity	____Colitis
____Psoriasis	____Mental Breakdown	____Hives
____Jaundice	____Herpes	____Gonorrhea

III. FAMILY HISTORY

List birthdates and health status of immediate family members. Write A/W if they are alive and well. Write in any illness(es) or if deceased, mark D and write cause.

Relationship DOB Health

Mother ____

Father ____

Sisters ____

____

Brothers ____

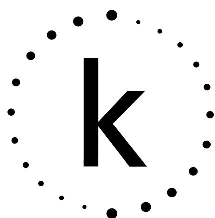
____

Maternal Grandmother ____

Maternal Grandfather ____

Paternal Grandmother ____

Paternal Grandfather ____



Do any of these illnesses run in your family and if so in whom?

________________Diabetes
________________Cancer
________________High Blood Pressure
________________Epilepsy
________________Heart Disease
________________Mental Illness
________________Tuberculosis
________________Thyroid Problems
________________Asthma
________________Obesity
________________Gout

IV. DIET AND EXERCISE

How do you feel about the foods you eat? -

____

____

Write the percentages in your diet of these food categories. Total 100%

_____Fruits _____Grains _____Dairy _____Vegetables
_____Nuts, Beans, Seeds _____Meats

List percentages of these meat categories

_____Red Meat _____Chicken _____Fish

What percent of your food is from restaurants? ___________
What percent of your food do you prepare? ___________

For the next categories, write the average number of times in a week these items are consumed in your diet.

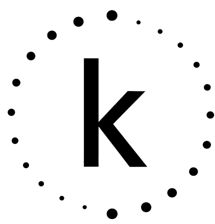
____Fried Foods ____White or Brown Sugar ____Food Additives (chemicals)
____Coffee ____Nicotine ____Alcohol ____Beer
____Wine ____Hard Liquor
____Drugs Which?____________________ Frequency ______________________

Is there one or more particular food flavors that you crave?
(Circle all that apply) Sweet Salty Spicy Bitter

Do you have a garden? _____
Do you enjoy exercise? _____ Mild? _____ Strenuous? ______

How often do you exercise in a week? ____

____



List exercises and Frequency

___________________________________ ____
___________________________________ ____
___________________________________ ____
___________________________________ ____

Do you sweat easily? ________ How often?________

Do you have any pets? ____ What kind and how many? ______________________________

V. GENERAL QUESTIONS

Are you able to express your emotions/feelings?

____
____
____

Do you predominantly feel any of the following?

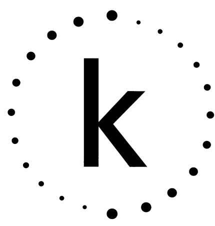
____Anger ____Sadness ____Fear ____Sympathy
____Worry ____Excessive Joy ____Depression ____Other

Are you too emotional or too unemotional? (explain)

____
____
____

What makes you nervous?

____
____
____



Is there much stress in your life? ____

If so, is it family, work, finances, relationships, ect.?
____
____
____

Do you sleep well? ______________________________ How many hours per night?_________________

Do you dream? _________________________________ How often? _____________________________
Do you remember any? __________________________ Are they helpful? _________________________

Are you happy with your general energy level? ____

Do you have a favorite time of day? ____

Do you have a favorite climate/weather? What is it? ____
____

Are there climates you especially don't like? Which are why? ____________________________________
____