

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

- diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
- other _____

Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation
- Depression Panic attacks Nausea Fecal incontinence Bleeding
- Disinterest in sex Headaches Vomiting Urinary incontinence Discharge
- Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date - last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
- Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk _____
- Run, jog, other aerobic - #days/wk _____

Weight lift - #days/wk _____**Stretch - #days/wk _____****Other _____****Nutrition & Diet**

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals - which ones _____
- _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Others _____

I Would Like To:ENERGY - VITALITY

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

BODY COMPOSITION

- Loose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

STRESS, MENTAL, EMOTIONAL

- Learn how to reduce stress
- Think more clearly and be more-focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

LIFE ENRICHMENT

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

FirstLineTherapy® Health Profile

NAME _____

DATE _____

Rate each of the following symptoms based upon your typical health profile for:

Past 30 days

Past 48 hours

Point Scale	0	Never or almost never have the symptom	3	Frequently have it, effect is not severe
	1	Occasionally have it, effect is not severe	4	Frequently have it, effect is severe
	2	Occasionally have it, effect is severe		

HEAD

Headaches
Faintness
Dizziness
Insomnia
TOTAL _____

EYES

Watery or itchy eyes
Swollen, reddened or sticky eyelids
Bags or dark circles under eyes
Blurred or tunnel vision
(does not include near-
or far-sightedness)
TOTAL _____

EARS

Itchy ears
Earaches, ear infections
Drainage from ear
Ringing in ears, hearing loss
TOTAL _____

NOSE

Stuffy nose
Sinus problems
Hay fever
Sneezing attacks
Excessive mucus formation
TOTAL _____

**MOUTH/
THROAT**

Chronic coughing
Gagging, frequent need to clear throat
Sore throat, hoarseness, loss of voice
Swollen or discolored tongue, gums
or lips
Canker sores
TOTAL _____

SKIN

Acne
Hives, rashes, dry skin
Hair loss
Flushing, hot flashes
Excessive sweating
TOTAL _____

HEART

Irregular or skipped heartbeat
Rapid or pounding heartbeat
Chest pain
TOTAL _____

LUNGS

Chest congestion
Asthma, bronchitis
Shortness of breath
Difficulty breathing
TOTAL _____

**DIGESTIVE
TRACT**

Nausea, vomiting
Diarrhea
Constipation
Bloating feeling
Belching, passing gas
Heartburn
Intestinal/stomach pain
TOTAL _____

**JOINTS /
MUSCLE**

Pain or aches in joints
Arthritis
Stiffness or limitation of movement
Pain or aches in muscles
Feeling of weakness or tiredness
TOTAL _____

WEIGHT

Binge eating/drinking
Craving certain foods
Excessive weight
Compulsive eating
Water retention
Underweight
TOTAL _____

**ENERGY /
ACTIVITY**

Fatigue, sluggishness
Apathy, lethargy
Hyperactivity
Restlessness
TOTAL _____

MIND

Poor memory
Confusion, poor comprehension
Poor concentration
Poor physical coordination
Difficulty in making decisions
Stuttering or stammering
Slurred speech
Learning disabilities
TOTAL _____

EMOTIONS

Mood swings
Anxiety, fear, nervousness
Anger, irritability, aggressiveness
Depression
TOTAL _____

OTHER

Frequent illness
Frequent or urgent urination
Genital itch or discharge
TOTAL _____

GRAND TOTAL _____