YOURLIMITLESSHEALTH

Confidential Health History

Name:

Address:

Email address: *Telephone:*

Who referred you to us?

Age: *Date of Birth:* *Place of Birth:*

Relationship status:

Current weight: *Weight six months ago:* *One year ago:*

Would you like your weight to be different?

Occupation:

Hours of work per week:

Are you happy with your job?

On a scale of 1-10 how stressed are you with your job?

What are your 3 main health goals you want to work on during this program?
1.
2.
3

Please list your main health concerns:

Other concerns?

What are some limiting belief systems that hold you back from meeting your goals?

Do you exercise? What kind? How often?

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Do you notice how you feel after eating certain foods?
Do you notice how you feel after exercising?

Any serious illness/hospitalizations/injuries/surgeries? Please list all, including in your childhood.

Do you have any metal in your body (stents, implants, etc.), a pacemaker or any other medical devices?

Do you have any metal fillings in your teeth?

What blood type are you? (If you don't know it, don't worry about it)

GENERAL:

Fatigue __ Poor sleep___ Night sweats___ Sweat easily___ Tremors ___Poor balance ___ Weight loss ___ Weight gain ___Bruise easily ___ Bleed easily ___ Low immune system ___ Frequent cold and flu ___ Increased sensitivity ___

SKIN AND HAIR:

Rashes __ Hives ___ Itching __Eczema ___ Acne ___ Dry skin __ Dull hair ___ Loosing hair __- in shower clumps come out _

Any other skin issues?

MUSCULOSKELETAL:

Overall body pain___ Neck pain ___ Upper back pain___ Lower back pain ___ Shoulder pain___ Knee pain ___ Hip pain ___ Foot/ankle pain___ Hand/wrist pain ___ Elbow pain___ Muscle weakness ___ Muscle cramps ___

Any other muscle, joint, or bone problems?

GASTROINTESTINAL:

Nausea___ Diarrhea___ Constipation___ Irregular bowels___ Excessive gas/bloating___ Indigestion___ Abdominal pain___ Rectal itching___ Heartburn___ IBS___ Coughing after eating___

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Any other issues with stomach or intestines?

RESPIRATORY:

Asthma___ Bronchitis___ Cough___ Shortness of breath___ Too much phlegm___ Pain with a deep breath___

Do you have any known or suspected allergies or sensitivities?

What kind?

What makes them worse?

HEAD:

Sinus problem___ Migraines___ Ringing in ear___ Facial pain___ TMJ___ Frequent headaches___ Recurrent sore throat___ Congestion___

Are any symptoms related to food___, hormones___, weather___, tension___, other___

STRESS:

Do you feel you function under a lot of stress?

What is your biggest stressor in your life right now?

What kind:

Occupational

Relationships

Financial

Physical

Emotional

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Other_____

Where do you think you hold your stress?

NEUROLOGICAL:

Dizziness___ Loss of balance___ Lack of coordination___ Poor memory___ Mental fog___ Numbness___ Seizures___ Nerve pain____ Other___

PSYCHOLOGICAL:

*Anxiety___ Depression___ Easily stressed__ Panic attacks___ Apathy___ Lack of motivation___ Easily getting angry___ Easily loosing patience___ Mostly happy_*

Do you take any supplements or medications? Please list:

Any healers, helpers, or therapies you have tried? Please list:

What food did you eat often as a child?

What's your food like these days?

Breakfast –

Lunch –

Dinner-

Snacks –

Liquids –

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Do you drink alcohol, what kind and how much?

Do you smoke or have ever smoked?

Do you drink coffee and how much?

What percentage of your food is home cooked?

What percentage is not?

Where do you get the rest from?

Do you crave sugar, coffee, cigarettes, or have any major addictions?

Do you feel depressed or sad often?

Have you ever taken any medication for that?

What are the things in life you do that make you happy?

Have you had major trauma in your life and when (death or illness in the family, parent's or your own divorce, job loss or change, major move, etc.)?

How would you rate your health on a scale 1 to 10?

How are you satisfied with you overall appearance presently on a scale 1 to 10?

Anything else you would like to share?

What would you like to improve in your health to make you function to the fullest potential? (List in order of priority)

If we were to work together for in a 3 month program, where do you want to be with your health mind, body and spirit once completed?