

Health History

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

How did you find us? Patient (who) : _____ Doctor (who) : _____ Staff (who) : _____

Date of Birth: ____ / ____ / ____ Gender (circle one): Male Female Marital Status (circle one): M D W S

Age: _____ Height: _____ Current weight: _____ Weight 6 months ago: _____

Employer: _____ Work #: _____ Ext: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Relationship status: _____ Children: _____ Pets: _____

Are you currently taking any medications or supplements? *(Please include regularly used over the counter medications)*.....

Medication Name	Dosage and Frequency

Supplements	Dosage and Frequency

Do you have any medication, food, or seasonal allergies?

Medication, Food or Seasonal Allergies	Reaction

Medication, Food or Seasonal Allergies	Reaction

Please list your main health concerns: _____

Please list your 3 main health & fitness goals: _____

At what point in your life did you feel best and why? _____

Please list any illnesses, hospitalizations or injuries: _____

How is/was the health of your mother? _____ How is/was the health of your father? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Do you take anything to help you sleep? _____

WOMEN'S HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

Reached or approaching menopause? Please explain: _____

Birth control history: _____

Do you experience yeast infections or urinary tract infections? Please explain: _____

Please list any current symptoms, such as pain, digestion issues, etc: _____

What have you tried in the past to achieve your nutrition and fitness goals? This includes any diet, supplements, books, etc.

What are the things you visualize yourself doing once you are healthy? _____

RATE YOUR MOVEMENT								
	None	Some	Always		None	Some	Always	
Climbing Stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housework.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Computer work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving/riding in cars.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Taking care of child.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Riding a bike.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yard work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stretching or yoga.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting weights.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Aerobic activity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

What is your story? Take time to reflect on your life events from birth to the present time. What have your life events been? Start with birth moving through the life stages. Some examples are a difficult birth, accidents, marriage, divorce, deaths, starting a business, job changes, and financial issues.

BIRTH TO 15 YEARS: _____

15 TO 30 YEARS: _____

30 TO 40 YEARS: _____

40 TO 50 YEARS: _____

50+ YEARS: _____

MY HYDRATION	
What is your average daily intake? (oz.)	
Water _____	Juice _____
Caffeine _____	Energy Drinks _____
Soft Drinks _____	Milk _____
Alcohol _____	Other (write in) _____

LABS & TESTING
In the past 3 years have you had these things checked:
Blood pressure: _____ Mammogram _____
Cholesterol: _____ Pap or pelvic exam: _____
Vitamin D level: _____ Omega 3's: _____
Lab work: _____ Date of lab work: _____
Please bring any recent copies of lab work to your appointment.

MY FUEL		
Think about how you eat in a typical week. Indicate what percent you eat of each of the following.		
<ul style="list-style-type: none"> • Processed Foods (cereal, bread, crackers, etc.) % _____ • Grains (wheat, rice, corn, etc.) % _____ • Good Fats (avocado, coconut oil, nuts & seeds, etc.) % _____ 	<ul style="list-style-type: none"> • Fast Food % _____ • Vegetables % _____ • Fruit % _____ • Dairy % _____ 	<ul style="list-style-type: none"> • Beef % _____ • Pork % _____ • Chicken % _____ • Fish % _____

MY MEDICAL PRACTICES
Mark the wellness disciplines you use.
<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Dental Care
<input type="checkbox"/> Exercise / Movement Classes
<input type="checkbox"/> Eye Care
<input type="checkbox"/> General Medical
<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Meditation / Prayer
<input type="checkbox"/> Nutritional Counseling
<input type="checkbox"/> Psychological Counseling
<input type="checkbox"/> Yoga

Circle the appropriate number 0-3 on all questions below. 0 as the least/never to 3 as the most/always.

DIGESTION

Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Frequent use of laxatives	0	1	2	3
Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Excessive belching, burping or bloating	0	1	2	3
Difficulty digesting fruits/vegetables; undigested foods found in stools	0	1	2	3
Roughage and fiber cause constipation	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	yes			no

NERVOUS SYSTEM

Have difficulty falling asleep	0	1	2	3
Have difficulty staying asleep; wake tired	0	1	2	3
Get ill often	0	1	2	3
Numbness and/or tingling in hands or feet	0	1	2	3
Frequent Headaches	0	1	2	3
Limited flexibility	0	1	2	3
History of severe falls	0	1	2	3
Have poor concentration	0	1	2	3
Wake up with pain	0	1	2	3
Go to bed with pain	0	1	2	3
Take over-the-counter pain medication	0	1	2	3
Take prescription pain medication	0	1	2	3
Multiple Accidents (car, bike, abuse)	0	1	2	3
Have a condition that is unidentified by my medical doctor	0	1	2	3

BLOOD SUGAR

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Eating relieves fatigue	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Must have sweets after meals	0	1	2	3

What foods did you eat often as a child? _____

When you were a child, was food used as a reward or punishment? _____

Did your mom or dad cook or did you eat out more? _____

How was your weight as a child? Were you average weight or heavier? _____

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____ What percentage of your food is home-cooked? _____

Where do you get the rest from? _____

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

The most important thing I should do to improve my health is: _____

Jackie Caldwell is not a physician or a psychologist, and the scope of her consultation services does not include treatment or diagnosis of specific illnesses or disorders. If you, the client, suspect you may have an ailment or illness that may require medical attention, then you are encouraged to consult with a licensed physician without delay.

Rather than dealing with treatment of disease, Jackie Caldwell focuses on wellness and prevention of illness through the use of non-toxic, natural nutritional therapies to achieve optimal health. Jackie Caldwell primarily educates and motivates clients to assume more personal responsibility for their health by adopting a healthy lifestyle and diet.

By signing below, you acknowledge that you understand that Jackie Caldwell is a nutrition consultant and not a physician and cannot diagnose or treat an illness.

Additionally, you promise to give Jackie Caldwell a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

Client's Signature _____ Date _____