Reednutrition

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Health History Questionnaire

Please fax, mail or email this and all other relevant reports/forms to be received at least 1 business day prior to your first session.

Name:_____ Date: _____

Address:_____ Date of birth:_____Age: _____

City: _____Zip: _____ SS#: _____

Home phone/fax: _____ Height/weight: _____

Work phone/fax:_____ Ideal weight: _____

Cell:_____Email: _____

Occupation (describe): _____

Referred by: _____ Insurance: _____

Your Health History

1. Briefly describe your health goals and what your expectations are for nutritional therapy:

_____

_____

_____

2. Please list any other health issues that concern you even if you feel they are unrelated to nutrition. Indicate how long you have had these conditions, any factors you suspect might contribute to them, and if you are being treated by a physcian:

_____

_____

_____

_____

_____

_____

_____

_____

3. Please detail your health history. Include childhood illnesses, stressful events. chronic or recurrent conditions or illnesses not listed above, surgeries, fractures, antibiotic use, birth control, hormone replacement, steroid use, etc:

_____

_____

_____

_____

_____

_____

_____

_____

For women only (men skip to question 9)

4. Age at first menses: _____

5. Are your menstrual periods normal? Yes_____ No ____ Please explain _____

6. Do you experience symptoms before or after your period? _____

_____

7. Number of pregnancies: _____Birthdays (include year) of children_____

8. Date of menopause: _____Describe any perimenopausal/menopausal symptoms you experience_____

_____

9. List all medications you currently take, including prescription, over-the-counter, and vitamin supplements:

Name of med/supp	Reason for taking	Dose	Frequency	Length of time using

10. Have you noticed any side effects from taking any of these medications/supplements? Yes _____ No _____
If yes, please explain _____

11. Date of last medical checkup and diagnosis:_____
Was your blood work done and will you submit a copy?_____
What was your blood pressure?_____

12. **Family health history:** Please circle the conditions mentioned below that are found in your family history. Please indicate who suffers from each condition:

Cancer	Heart disease	Multiple Sclerosis	Allergies
Diabetes	Lung disease	Muscular Dystrophy	Chronic fatigue
Lupus	Alcoholism	Obesity	Thyroid disease
Asthma	Drug abuse	Ulcers	Ulcerative colitis/Crohn's
Arthritis	Kidney disease	Liver disease	High blood pressure
Psoriasis	Eating disorder	Hormonal disorder	Circulatory problems
Osteoporosis	Alzheimer's	Macular Degeneration	Celiac

13. Do you currently smoke? Yes _____ No_____ If yes, how much? _____

14. Have you smoked in the past? How much and when did you stop?_____

15. Have you ever had any worm, parasite, bacterial or yeast infections? Yes _____No _____ If yes, please circle.

16. Do you experience any of the following on a regular basis? Yes _____ No _____ If yes, please circle:

Lack of appetite	Diarrhea	Constipation	Indigestion
Gas	Bloating	Nausea	Vomiting
Reflux	Abdominal cramps/pain	Difficulty chewing or swallowing	

17. How many times per day do you have a bowel movement?_____Per week average _____

18. Do you use laxatives or other medications to promote eliminations? Yes_____No_____

19. Describe stool quality _____

20. Do you exercise regularly? Yes ____ No_____ If so, please indicate type of exercise, frequency, duration: _____

_____

21. Please rate your energy level on a scale of one to five: 1 2 3 4 5

22. Is there a time of day that you are less energetic?_____

23. Please rate how stressful your life is on a scale of one to five: 1 2 3 4 5

24. Do you sleep well?_____How many hours of sleep do you typically get each night? _____

_____

25. What is your blood type? O _____A _____ B _____ AB _____

26. What was your lowest weight as an adult?_____ What was your highest weight as an adult?_____

27. Have you recently lost or gained 10 lbs.? Yes___ No____ If yes, please explain: _____

_____

Eating History

1. Are you on a special diet now or have you been in the past? Why? With what results?_____

_____

2. Are you allergic to any foods or substances? Yes_____ No _____ If yes, please list and describe your symptoms

_____

_____

3. Do you sometimes get sleepy, headaches, or other symptoms after eating certain foods? Yes _____No _____
   If yes, please give specifics _____

4. Please list the 10 foods you eat most often _____

_____

5. Please list the foods you do not eat: _____

6. Where do you eat most of your meals and who do you eat with? _____

7. Do you cook? _____

8. Where do you shop for food? _____

9. With whom do you live? _____

10. Are there any other facts about your lifestyle that you think might be related to your nutritional health? _____
    Please explain:_____

If you have any recent blood work or medical records pertaining to your current condition(s), please attach these to this questionnaire.