Health Evaluation Profile

Important:

1. Please **fast for 3 hours** prior to your appointment. No food or drink except water.
2. Please hydrate as much as possible. **Drink at least 3 glasses of water** before your appointment, and void your bladder as necessary.

Name: Date of birth: Age: Sex: Blood type A B AB O not sure Marital status: Number of children: Referred by:	Phone: Email: Address: Emergency contact name: Relationship: Phone:

List paternal family diseases:

List maternal family diseases:

List any food or environmental allergies:
Do you have pets? Y [ ] N [ ]
What kind?:
What type of exercise do you do?
How often and duration?
Do you have a bowel movement every day? Y [ ] N [ ]
How many per day?
Do you experience digestive difficulties (bloating, constipation, gas, etc)? Y [ ] N [ ]
Describe:

Health History

Have you ever been hospitalized for surgery? Y [ ] N [ ]
When and what for?

List all supplementation (vitamins, minerals, herbs) you are taking:

List all prescription medication you are taking and why you are taking it:

Describe any health issues/problems you are currently experiencing and specify your main concern:

Diet

# of coffees per day:

For how many years?

If you quit, how long ago?

# of carbonated beverages per day

Any diet drinks?

For how many years?

If you quit, how long ago?

Do you consume alcohol Y [ ] N [ ]

If so, how much and how often?

How many ounces of water to you drink per day?

What is the source of your drinking water?

How many servings of fruit do you eat per day?

How many servings of vegetables do you eat per day?

Are the fruits and vegetables organic?

Provide any other information that may be relevant, but hasn't been covered in regard to diet:

Stress

On a scale of 1 to 10, how stressful is your occupation?

On a scale of 1 to 10, how harmonious is your family life?

On a scale of 1 to 10, how satisfying are your friendships?

Briefly describe any stressful situations in you life right now:

Do you take time for yourself?

What does this look like to you? (Ie. time alone, tv, working out, laying down, shopping, spa treatments):

How often?

Radiations

Do you use a computer? Y [ ] N [ ]
How long each day?
Do you use a cell phone or tablet? Y [ ] N [ ]
How long each day?
Are you exposed to fluorescent lights at work or home? Y [ ] N [ ]
How often do you travel by plane?
When was the last time?
Do you use a microwave oven? Y [ ] N [ ]
How often?

Chemicals

Where did you live while growing up? (city, country)
Occupation:
What type of environment do you work in? Office [ ] Factory [ ] Other (describe)[ ]
Are you exposed to chemicals at work? Y [ ] N [ ]
Name them:
Any tatoos? Y [ ] N [ ]
How many cigarettes do you smoke per day
For how many years?
If you quit, how long ago?
How many dental fillings do you have?
Have you had any removed?
How many?
Date of most recent removal:
How many root canals do you have?
Date of most recent:
Do you have crowns or other metals (braces, partials, retainers)
Do you, or have you used aluminium cookware? Y [ ] N [ ]
Do you use spray deodorants or antipersperants? Y [ ] N [ ]
Do you use antacids? Y [ ] N [ ]
Are you, or have you ever, taken birth control pills? Y [ ] N [ ]
For how long?
If you quit, how long ago?
Have you ever been on hormone replacement therapy? Y [ ] N [ ]
For how long?

If you quit, how long ago?

Have you ever had shots of vaccinations (including flu shot) Y [ ] N [ ]

Which ones?

How long ago?

What drugs have you taken during your life, recreational or prescribed (in addition to the ones you are currently taking, listed above):

Have you ever been on antibiotics? Y [ ] N [ ]

How often?

For what reasons?

Date of last prescription?

Type?

For what?

Have you ever lived near any farms or large agricultural projects? Y [ ] N [ ]

What kind (dairy, vegetable, orchard, greenhouse)?

When?

Do you dry-clean your clothes? Y [ ] N [ ]

Any renovations in your home within past 12 months?

Describe:

List cosmetics/makeup you use regularly. Specify if natural:

List household cleaning products that you are exposed to. Specify if natural:

If there anything that will get in the way of following a treatment plan in order to achieve results?