Name_____DOB_____
Date_____

HEALTH HISTORY

Current concerns: List up to 4 (please be concise):
1.
2.
3.
4.

How old were you when you last felt well for at least 6-12 months? _____

When did you begin to notice chronic symptoms: Age_____Date_____
List significant life events related to your symptoms and the age at which they occurred:
Age____ Symptoms_____
Age____ Symptoms_____
Age____ Symptoms_____
Age_____Symptoms_____

Health of your parents before you were born:
Mom's health prior to or during pregnancy:
Good____ Fair____ Poor____ Unknown____
Did she use alcohol, tobacco or recreational drugs while pregnant with you? Yes___No___

Dad's health prior to mom's pregnancy:
Good____ Fair____ Poor____ Unknown____
Did he use alcohol, tobacco or recreational drugs? Yes____ No____

Peri-natal events – circle those which apply to you:
Vaginal birth C-section Unknown if vaginal or cesaerean
Premature or stressful birth Time spent in ICU after birth
Antibiotics at birth or shortly thereafter_____
Breast fed – if yes, number of months:_____ Bottle fed_____

Childhood heath
Where were you born?_____ and raised?_____
How many siblings do you have? _____
Childhood health: Good_____ Fair_____ Poor_____
Major stressors in childhood_____
Symptoms or illnesses in childhood_____
Toxin exposures in childhood_____
Nutrition in childhood: Good_____ Fair_____ Poor_____

Energy/Mitochondrial Health – please circle any that are problematic for you now:
Fatigue Chronic headaches Worsening memory
Heart disease Macular degeneration Retinal disease

Infections: circle the infections that you have had in your life:
Infectious mononucleosis (Epstein-Barr) Lyme Disease Babesiosis
Mold exposure Traveler's diarrhea Other gastroenteritis
Pneumonia Sinusitis Other_____
How many times per year do you get colds or other upper respiratory infections?_____

Antibiotic exposure
Age of first antibiotic use (approximately)_____
Number of courses of antibiotics you have taken antibiotics in your lifetime:
Less than 5 courses___5-10 courses___ 11-20 courses___More than 20 courses____

Hormone Health: please circle all that apply to you:
Chronic stress (elevated cortisol) Frequent use of steroids eg prednisone
Low vitamin D Thyroid hormone issues
Infertility Endometriosis Pelvic pain Polycystic ovaries
Hot flashes Night Sweats Low libido Erectile dysfunction
Low fat, low cholesterol diet

Women only:
Have your used birth control pills in the past? _____
How many pregnancies have you had? ____
Miscarriages: _____
Abortions: _____
Have you gone through menopause? ___ if yes, at what age?. Have you taken hormones for menopause? ____ Are you currently having menopausal symptoms? _____

Toxin exposures <u>currently or in the past</u> – please circle all that apply to you, and then please <u>cross out</u> the ones that you are <u>no longer</u> exposed to:
Private well Pesticides Mercury (silver) dental fillings
Commercial self-care products like shampoo, deodorant, lotions
Fragrance other than essential oils or true perfumes
Commercial cosmetics Hair dye Nail polish
Commercial cleaning products Canned foods Coated cash-register receipts
Aluminum or non-stick cookware Use of plastic water bottles
Industrial solvents Welding Art/hobbies like oil painting
EMF exposure (frequent use of cell phones, computers, tablets, wifi, cordless phones, routers.
Do you have a SmartMeter installed in your home? _____

How often do you eat tuna-fish, swordfish, shark, or tilefish: _____ servings per week (these tend to be high in mercury).
How much rice do you eat?_____ How much chicken do you eat?_____ (these can be high in arsenic)
Do you eat hot sauce or candies imported from Mexico?____ (may be contaminated with lead)

Where were you raised, ie, on a farm, in the city, in an industrial area? _____

Substance use:
How much caffeinated coffee or tea do you drink? _____ ounces per day
What kind of alcohol do you drink, and how much per week?_____
Any tobacco use in the past?_____ If yes, how much?_____ Quit date_____
Other substance use or abuse?_____

Physical Trauma – Any history of any of the following? Circle all that apply:
Concussion Loss of Consciousness Any other head injury or blow to the head
Neck injuries Sports injuries Car or motorcycle accident Falls

Nutrition
Circle the diets you have followed in the past:
Standard American Diet Mediterranean Diet South Beach Diet
Vegetarian diet Vegan diet Pescetarian diet Dairy-free diet
Paleo diet Ketogenic diet Autoimmune diet Gluten-free diet Atkins diet
Other_____

Which dietary pattern do you follow now?_____For how long?_____
Do you or other family members cook at home? If not, are you willing to start?_____
How many meals do you eat every day?_____ How many snacks?_____
How many meals do you eat out every week?_____
How many cups of vegetables and fruit do you eat every day?_____
How often do you eat fermented foods? (kefir, sauerkraut, etc)_____
How often do you eat fatty fish like salmon, mackerel, or sardines?_____
How many ounces of water do you drink every day?_____
How many ounces of the following do you drink every day:
juice_____ soda (regular or diet)_____ sports drinks_____ other_____

Digestion
Do you have bloating, gas, constipation, or diarrhea?_____
Have you had your gallbladder removed?_____
Consistency of bowel movements:
Soft, bulky and easily expelled_____ loose_____ rocks and pebbles_____
How many bowel movements do you have every day on average?_____

Please circle the medications that you are taking now or have taken in the past:
PPIs (eg, Prilosec, Prevacid, Nexium) H2 Blockers (eg, Zantac, Pepcid)
NSAIDs (eg Motrin, Aleve) Prednisone

Dental Health
How many cavities have you had in your life?____ Date of last cavity_____
How many root canals have you had?_____ Are they causing any symptoms?_____
Do you have or have you had gingivitis or periodontal gum disease?_____
Do you floss and brush your teeth at least once/day?_____

Sleep
What time do you go to bed?_____ What time do you get up? _____
How many times do you get up at night?_____ For what reason?_____
How many hours of sleep do you get every night on average?_____
Is your sleep quality good, fair, or poor?_____ Do you feel rested in the am?_____
Do you snore?_____ Do you think you might have sleep apnea?_____

Exercise
How many times per week?_____
How many minutes total per week?_____
Types of exercise you engage in:_____
If you don't exercise, why not? _____

Social History
Are you married?____ How many times?_____ How long?_____
if not, do you currently have an intimate relationship?_____ Are you satisfied with your intimate relationship(s)?_____
How many children do you have?_____ Ages_____
With whom do you live?_____
Any pets?_____
How much education have you had?_____
What kind of work do you do?_____
Are you satisfied with your career?_____ If not, what would you rather be doing?_____

Stress and Resilience:
Write down how old you were when you were affected by any of the following events. If they occurred multiple times, please note your age at each occurrence:
Divorce_____ Family conflicts_____ Poverty_____ Food insecurity/hunger_____
Death of family members or close friends_____
Physical abuse_____ Emotional abuse_____ Sexual abuse_____
Toxic relationships_____ Work conflict_____ Financial stress_____
Other trauma_____
Have you ever served in the armed forces? If yes, were you involved in combat?_____

What is your current stress level on a scale of 1 to 10, if 10 is the worst?_____
Current sources of stress_____
What are your current stress reduction practices – circle all that apply:
Meditation Mindfulness Deep breath work Guided Imagery
Heart Math Self-hypnosis Prayer Yoga Tai Chi Qi Gong
Hiking or time in nature Fishing Gardening Exercise
Journaling what is upsetting for you Gratitude journaling Forgiveness work
Spending time with your pet(s) Laughter exercises Volunteer work
Massage Epsom salt baths
Playing music Singing Creative writing Dancing Doing artwork

How many minutes a day are you spending in these practices?_____

What pleasurable leisure activities or hobbies are you engaged in now?

Do you have a confidante or supportive individuals in your life?_____
Are you at peace with your family of origin?_____
Are you part of a community group (church, book club, etc)?_____
Do you do any volunteer work?_____ Please describe_____

Is your self-talk mostly supportive?_____ If not, what can you do to turn that around?

_____

What helps you to get back on your feet when you feel that life has knocked you down?

_____

Describe a time in the past when you recovered from or overcame a difficult situation:

_____

What is your purpose or your mission in your life? Why do you want to heal, ie, how would you be able to fulfill on your life's mission if you were well again?

_____

What wisdom, insights, or gifts have come to you as a result of being ill or facing a medical challenge?

If you knew that you had only 1 more year to live, would you have regrets? _____ Would you change anything in your life right now?

_____

Is your spiritual life satisfactory to you?_____

Where do you feel a connection with something greater than yourself? (eg, many people feel this in nature).