

# Health History

<b>OFFICE USE ONLY</b>
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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

How do you prefer to be contacted?  Phone  Text  Email Occupation: \_\_\_\_\_

Marital Status:  Single  Partnered  Married  Separated  Divorced  Widowed

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female Height (ft): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

How did you hear about the SHAPE Program? \_\_\_\_\_

BLOOD WORK: If you have recent blood work (within the last 6 months), please include a copy with this form.

## QUESTIONNAIRE

What are your three most important current health concerns?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

List any medical problems currently being managed by a physician: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any surgeries with dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any allergies to food, drugs or other known allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all supplements you are taking on a routine (daily - monthly) basis, include dose: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List all prescription and over-the-counter drugs you are taking on a routine (daily - monthly) basis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you tried the SHAPE Program previously? If so, when? \_\_\_\_\_

What was/wasn't successful about the SHAPE Program? \_\_\_\_\_

What other programs have you tried? \_\_\_\_\_

What was/wasn't successful about the other program(s)? \_\_\_\_\_

What are the main stresses in your life? \_\_\_\_\_

Have you experienced any life-changing stressful events? \_\_\_\_\_

What do you do to de-stress? \_\_\_\_\_

What are some of your hobbies? \_\_\_\_\_

Why do you want to do the SHAPE Program? \_\_\_\_\_

What is your activity level on a scale from 1-10? (10 being very active) \_\_\_\_\_

What is your average energy level on a scale of 1-10? (10 being the optimal energy level you think you *should* have) \_\_\_\_\_

Do you feel you get adequate sleep?  Yes  No \_\_\_\_\_

Do you wake rested?  Yes  No \_\_\_\_\_

Do you wake during the night? At what time?  Yes  No \_\_\_\_\_

Do you sleep next to any electronic devices?  Yes  No \_\_\_\_\_

Do you exercise?  Yes  No \_\_\_\_\_

Do you follow any particular diet?  Yes  No \_\_\_\_\_

Do you consume caffeine daily?  Yes  No \_\_\_\_\_

Do you use tobacco?  Yes  No \_\_\_\_\_

Do you consume alcohol?  Yes  No \_\_\_\_\_

Do you feel you've ever had a problem with overuse of drugs or alcohol?  Yes  No \_\_\_\_\_

Do you have a good support system?  Yes  No \_\_\_\_\_

Do you have a spiritual practice?  Yes  No \_\_\_\_\_

**SYMPTOMS/CONDITIONS**

Check the boxes of symptoms/conditions that you have experienced over the last 6 months.

**Wood:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Back pain           | <input type="checkbox"/> Gallbladder problems    | <input type="checkbox"/> Muscle cramps   |
| <input type="checkbox"/> Brittle nails       | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Bursitis/Tendonitis | <input type="checkbox"/> Irritable/Angry         | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Hepatitis/Liver disease | <input type="checkbox"/> Paralysis       |

**Fire:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anxiety                     | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Palpitations      |
| <input type="checkbox"/> Bleed or bruise easily      | <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Memory loss       |
| <input type="checkbox"/> Chest pain/pressure         | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Nose bleeds       |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Hot/Cold intolerance | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Environmental sensitivities | <input type="checkbox"/> Hyperthyroid         | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Fainting/Dizziness          | <input type="checkbox"/> Hypothyroid          | <input type="checkbox"/> Tremors           |
| <input type="checkbox"/> Food intolerances           | <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Varicose veins    |

**Earth:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acid reflux             | <input type="checkbox"/> Gas/Bloating       | <input type="checkbox"/> Irritable when hungry |
| <input type="checkbox"/> Abdominal Pain          | <input type="checkbox"/> Hemorrhoids        | <input type="checkbox"/> Nausea/Vomiting       |
| <input type="checkbox"/> Cold/Canker sores       | <input type="checkbox"/> Hypoglycemia       | <input type="checkbox"/> Tired after eating    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Indigestion        | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Excessive thirst/hunger | <input type="checkbox"/> Insulin resistance | <input type="checkbox"/> Worrisome             |

**Metal:**

- |   |                                     |   |
|---|-------------------------------------|---|
| <input type="checkbox"/> Acne           | <input type="checkbox"/> Eczema     | <input type="checkbox"/> Rashes/Itchiness       |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Respiratory infections |
| <input type="checkbox"/> Constipation   | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Shortness of breath    |
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Hay fever  | <input type="checkbox"/> Sinus problems         |
| <input type="checkbox"/> Despair/Apathy | <input type="checkbox"/> Hives      | <input type="checkbox"/> Skin tags              |
| <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Psoriasis  | <input type="checkbox"/> Wheezing/Hoarseness    |

**Water:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Kidney stones      |
| <input type="checkbox"/> Chronic urinary tract infections | <input type="checkbox"/> Hair loss               | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Dentures                         | <input type="checkbox"/> Hearing loss            | <input type="checkbox"/> Low libido         |
| <input type="checkbox"/> Edema                            | <input type="checkbox"/> Incontinence            | <input type="checkbox"/> PMS                |
| <input type="checkbox"/> Excess libido                    | <input type="checkbox"/> Infertility             | <input type="checkbox"/> Prostate issues    |
| <input type="checkbox"/> Fearful                          | <input type="checkbox"/> Joint pain              | <input type="checkbox"/> Ringing in ears    |

**Other:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Autoimmune disease        | <input type="checkbox"/> Hernia                       | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Bleeding gums             | <input type="checkbox"/> History of abuse             | <input type="checkbox"/> Restless legs         |
| <input type="checkbox"/> Employment difficulties   | <input type="checkbox"/> History of antibiotic use    | <input type="checkbox"/> Schizophrenia         |
| <input type="checkbox"/> Erectile dysfunction      | <input type="checkbox"/> History of vaccine reactions | <input type="checkbox"/> Serious head injury   |
| <input type="checkbox"/> Children (list age) _____ | # Bowel movements/day _____                           |  |

**Women Only:**

- Breast masses
- Lack of periods
- Spotting
- Hysterectomy
- Menopause (age) \_\_\_\_\_
- Vaginal discharge
- Irregular periods
- Painful/Heavy periods
- Yeast infections
- Pregnancies # \_\_\_\_\_
- C-section # \_\_\_\_\_
- Miscarriage #/date \_\_\_\_\_

Are you/Do you plan to become pregnant?  Yes  No \_\_\_\_\_

Are you breastfeeding?  Yes  No \_\_\_\_\_

Are you taking birth control? What kind?  Yes  No \_\_\_\_\_

Are you on hormone replacement therapy?  Yes  No \_\_\_\_\_

**INFORMED CONSENT**

I, \_\_\_\_\_, understand that the SHAPE Program is a lifestyle modification, health restoration program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary healthcare experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dose adjustments. I agree to notify my prescribing physician that I am working with \_\_\_\_\_ and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutrition protocol will be recommended based on my unique health history, urinalysis and symptoms.

**NOTES (Practitioner only)**

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