Personal Health Evaluation

Note: Information provided on this form will be held in strict confidence.

Personal Information

Name_____ Age _____

Sex (optional) _____ Gender (optional) : _____ Height_____Weight _____

Phone Number: _____ Email:_____

For Natal Chart, optional: This info is on your birth certificate:

Place of Birth (City, State, Country): _____

Time of Birth: _____ AM PM

Diet, Nutrition and General Health Practices

What is a typical meal for you, for Breakfast, Lunch, Dinner, and Snacks? Include Beverages.

Breakfast/Morning Snacks: Typical vs Present

Lunch/Afternoon Snacks: Typical vs Present

Dinner/Evening Snacks: Typical vs Present

Typical Alcohol Consumption: Typical vs Present

Any other recreational drugs or rituals: Typical vs Present

What foods do you enjoy the most? ie: savory vs sweet, hot vs cold foods and drinks, spicy or bland, fatty or light: Typical vs Present

What foods do you feel guilty about eating, if any? Typical vs Present

What foods do you feel you should eat more of? Typical vs Present

What supplements are you currently taking, if any?

How much water do you drink each day? Typical vs Present

What kind of water do you drink? Typical vs Present

How much sleep do you get each night on the average? Typical vs Present

How do you sleep? Typical vs Present

How often do you exercise? Typical vs Present

What do you do for exercise? Typical vs Present

What is your energy level like? Typical vs Present

How often do your bowels eliminate? Typical vs Present

Are you pregnant or nursing a baby?

Do you feel like you are under stress? If so, explain. Typical vs Present

What do you enjoy doing and/or how do you relieve stress?

What current health concerns are you seeking help for? Be as detailed as possible, as necessary:

What medications, medical procedures, supplements or therapies have you previously tried for your health or current condition (attach separate sheet if necessary)? Were any of these supplements or therapies helpful? If so, please note which ones were helpful, if any?

Medical Information and History

Are you under a medical doctor's care for your condition?

If so, what are you being treated for?

Are you currently taking any prescription or over-the-counter drugs?

If so, please list each drug and what it is for.

Have you been diagnosed by a licensed physician with any of the following? Check all that apply.

❑ AIDS
❑ Angina
❑ Arthritis (Rheumatoid)
❑ Arthritis (Osteo)
❑ Arrhythmia (irregular heart beat) ❑ Asthma
❑ Autoimmune Disorders, Specify:

❑ AIDS
❑ Angina
❑ Arthritis (Rheumatoid)
❑ Arthritis (Osteo)
❑ Arrhythmia (irregular heart beat) ❑ Asthma
❑ Attention Deficit Disorder
❑ Autoimmune Disorders, Specify:

❑ Benign Prostatic Hyperplasia (BPH)
❑ Bipolar Mood Disorder (Manic Depressive Disorder)
❑ Bleeding Disorders
❑ Cancer, Specify type:
❑ Cardiac Arrest (Heart Attack) ❑ Celiac Disease
❑ Chronic Obstructive Pulmonary Disorder (COPD)
❑ Cirrhosis of the Liver
❑ Colitis
❑ Congestive Heart Failure ❑ Depression
❑ Diabetes
❑ Eczema
❑ Endometriosis
❑ Epilepsy

❑ Fatty Liver Disease
❑ Fibromyalgia
❑ Graves Disease (Hyperthyroid)
❑ Hahsimoto's Disease (Thyroiditis)
❑ Hepatitis
❑ High Blood Pressure (Hypertension)
❑ Irritable Bowel Disorder (Crohn's or Colitis)
❑ Kidney Stones
❑ Low Thyroid (Hypothyroid) ❑ Lupus
❑ Multiple Sclerosis
❑ Obsessive-Compulsive Disorder ❑ Osteoporosis
❑ Psoriasis
❑ Ulcers

Any other prior diagnosis:

Specific Emotional Symptoms

Check any of the following emotions you find it difficult to deal with, either in yourself or others.

- ❑ Anger
- ❑ Irritability
- ❑ Frustration
- ❑ Anxiety
- ❑ Fear
- ❑ Sadness
- ❑ Depression
- ❑ Excitement
- ❑ Laughter
- ❑ Lack of enthusiasm
- ❑ Lack of joy
- ❑ Worry

Explain the checked above, in detail in regards to yourself and others: Typical and Present:

Digestive, Liver and Intestinal Symptoms.

- ❑ Abdominal pain or discomfort
- ❑ Acid indigestion, heartburn or acid reflux
- ❑ Bad breath
- ❑ Bloating, belching or intestinal gas
- ❑ Constipation (bowel movements less than once per day)
- ❑ Cravings for sugary foods
- ❑ Diarrhea or loose stools:
- ❑ Food allergies, specify foods that give you problems:
- ❑ Gingivitis or gum disease
- ❑ Food sits heavy on stomach after meals
- ❑ Groggy feelings in the morning
- ❑ Hard, dry stools
- ❑ Hemorrhoids or anal fistula
- ❑ Loss of appetite or poor appetite
- ❑ Loss of smell or taste
- ❑ Sensation of lump in throat
- ❑ Stomachache
- ❑ Under weight or unable to gain weight
- ❑ Family history of heart disease
- ❑ High cholesterol, specify:

Respiratory System Symptoms.

- ❑ Chronic or frequent cough
- ❑ Cold sores
- ❑ Excess mucus production
- ❑ Frequent infections
- ❑ Hayfever and respiratory allergies
- ❑ Post nasal drip
- ❑ Sinus headaches
- ❑ Sinusitis or chronic sinus congestion
- ❑ Wheezing or shortness of breath
- ❑ Itchy nose or ears

Circulatory System Symptoms

- ❑ Anemia
- ❑ High triglycerides, specify:
- ❑ Irregular heart beat, arrhythmia
- ❑ Rapid heart beat
- ❑ Swelling in lower extremities
- ❑ Varicose veins or spider veins
- ❑ Wounds that won't heal in the extremities
- ❑ Cold hands and feet
- ❑ Heart palpitations
- ❑ High blood pressure, specify blood pressure
- ❑ Chest Pain

Urinary and Fluid System Symptoms.

- ❑ Bladder infections
- ❑ Blood in the urine
- ❑ Burning or painful urination
- ❑ Difficulty starting urination
- ❑ Excessive perspiration
- ❑ Frequent pale urine
- ❑ Frequent urination
- ❑ History of kidney stones
- ❑ Puffiness under eyes
- ❑ Scant, dark urine
- ❑ Urinary incontinence (dribbling)
- ❑ Urinary tract infections (UTIs)
- ❑ Water retention or edema
- ❑ Swollen lymph nodes
- ❑ Frequent Thirst

Glandular System Symptoms

- ❑ Burning sensations in hands and feet
- ❑ Cold hands and feet
- ❑ Dark circles under eyes
- ❑ Dry skin
- ❑ Excess weight
- ❑ Excess weight around the abdomen
- ❑ Fatigue in the afternoons
- ❑ Fatigue, chronic or excessive
- ❑ Feeling chronically stressed
- ❑ Feeling exhausted, "burned-out"
- ❑ Frequent Thirst
- ❑ Hair loss or thinning
- ❑ Lack of stamina
- ❑ Loss of short-term memory
- ❑ Low body temperature, easily chilled
- ❑ Mental sluggishness, "brain fog"
- ❑ Mood swings
- ❑ Muddled thinking, confusion
- ❑ Restless disturbed sleep
- ❑ Restless dreams or nightmares
- ❑ Waking up at night unable to go back to sleep
- ❑ Waking up frequently at night
- ❑ Difficulty urination

Reproductive System and Sexuality

- ❑ Erectile dysfunction
- ❑ Infertility
- ❑ Lack of sex drive
- ❑ Depression with periods
- ❑ Edema or bloating associated with periods
- ❑ Heavy menstrual bleeding
- ❑ Hot flashes and/or night sweats
- ❑ Infertility
- ❑ Irritability with periods
- ❑ Lack of sexual desire
- ❑ Night sweats
- ❑ Pain in the mid to low back
- ❑ Loss of self-confidence and drive
- ❑ Nighttime urination
- ❑ Prostate problems
- ❑ Urinating at night
- ❑ Menstrual cramps
- ❑ Nursing (currently)
- ❑ Painful menstruation
- ❑ PMS
- ❑ Post-menopausal
- ❑ Pregnant (currently)
- ❑ Vaginal discharge
- ❑ Vaginal dryness

Nervous System Symptoms.

- ❑ Absent-mindedness
- ❑ Difficulty getting to sleep
- ❑ Dizziness or light-headedness.
- ❑ Excitability, difficulty relaxing
- ❑ Feeling depressed or discouraged
- ❑ Headaches
- ❑ Tension headaches with tight, constricted feeling
- ❑ Alcoholism
- ❑ Anxiety, nervousness
- ❑ Chronic muscle tension
- ❑ Pounding headaches
- ❑ Headaches around eyes or forehead
- ❑ Migraines
- ❑ Loss of memory
- ❑ Panic attacks
- ❑ Peripheral neuropathy
- ❑ Poor concentration
- ❑ Shaky hands
- ❑ Drug Addiction
- ❑ Sweats/Night Sweats

Structural System Symptoms.

- ❑ Acne
- ❑ Arthritis
- ❑ Back pain
- ❑ Brittle fingernails
- ❑ Eczema
- ❑ Gout
- ❑ Itching, skin
- ❑ Joint pain
- ❑ Leg cramps or pains
- ❑ Multiple root canals
- ❑ Muscle cramps
- ❑ Neck pain
- ❑ Osteoporosis
- ❑ Rashes
- ❑ Rosacea
- ❑ Stiff, aching or painful muscles
- ❑ Teeth grinding
- ❑ Tense muscles
- ❑ Weak legs, knees or ankles

Add any additional information you feel may be helpful in evaluating your situation. Anything notable from Past, Typical, or Present: