

**Health History Questionnaire**

**Name:**

**Age:**

**Height:**

**Weight:**

**Estimated Body Fat (BF) Percentage (write your body fat per**A collage of different types of women's body

Description automatically generatedA collage of a person's body

Description automatically generated**centage here):**   
(Please use the pictures below to estimate your current body fat percentage)

**Activity & Exercise**

How many days per week do you exercise on average?

What type of exercise do you typically do?

Where would you estimate your daily activity to be based on the descriptions

below? (Please write the activity level here —>)

**Sedentary**

People in sedentary occupations, like urban office workers, typically use motor vehicles, engage in minimal exercise, and spend leisure time in activities involving little physical movement.

**Lightly Active**

Moderately active individuals have jobs requiring more activity than sedentary roles, while some with sedentary jobs include moderate activities like walking or cycling for daily commutes.

**Active**

Active lifestyles involve engaging in activities such as extended periods of walking or manual labor in occupations, brisk walking with a load, and tasks like operating heavy tools, farming, or construction work.

**Moderately Active**

Heavy housework includes moving heavy furniture, carrying items upstairs (25 lbs or more), and tasks like shoveling coal. Vigorous activities involve strenuous work or leisure, such as swimming or dancing for at least two hours daily, non-mechanized agricultural labor with heavy tools, and walking long distances over rugged terrains.

**Vigorous**

People with vigorous lifestyles engage regularly in strenuous work or leisure, such as non-mechanized agricultural laborers performing physically demanding tasks for several hours, often entailing walking long distances with heavy loads.

**Vigorously Active**

Weeks of competitive cycling, hauling sleds across the Arctic, or professional athletics.

**Goals** (Please list your goals in working together):

1)

2)

3)

4)

5)

**Timeline** (Please circle your expected timeline in achieving your goals):

3-6 months

6-9 months

9-12 months

**Commitment**

How important is your health and function to you on a scale from 1-10? (10 being the most important, 1 being the least important)

How committed are you to reaching your health goals on a scale from 1-10? (10 being the most committed, 1 being the least committed)

How willing are you to make changes to your lifestyle/ diet/ exercise routine/ supplement routine/ sleep routine/ etc., in order to reach your goals on a scale from 1-10? (10 being the most willing, 1 being the least willing)

**Medical History** (Please include any major medical history including surgeries, injuries and major medical diagnoses you’ve had)

1) Event/ Diagnosis:   
Description:

2) Event/ Diagnosis:   
Description:

3) Event/ Diagnosis:   
Description:

4) Event/ Diagnosis:   
Description:

5) Event/ Diagnosis:   
Description:

6) Event/ Diagnosis:   
Description:

7) Event/ Diagnosis:        
Description:

8) Event/ Diagnosis:   
Description:

9) Event/ Diagnosis:   
Description:

10) Event/ Diagnosis:   
Description:

**Diet History** (Please include any major dietary interventions/ ideologies you have tried. Please indicate which diet intervention/ ideology worked best for you and why)

1. Diet:   
   Description:

2) Diet:   
Description:

3) Diet:   
Description:

4) Diet:   
Description:

5) Diet:   
Description:

**Current Medications** (Please include medication, dosage, & timing)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

**Current Supplements** (Please include supplement, dosage, & timing)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

**Stress Levels**

How many hours do you typically work per day?

How many hours do you typically work per week?

What hobbies, interests, or activities do you currently enjoy doing? (Please list)

1)

2)

3)

4)

5)

How would you rate your general work stress level on a scale of 1-10 over the past month? (10 being the highest, 1 being the lowest)

How much stress is your current health challenge giving you on a scale from 1-10? (10 being highest, 1 being the lowest)

What is your current relationship status? (single, partnered, married, divorced, widowed, etc.)

How much stress do you currently experience in your important relationships on a scale of 1-10? (10 being the highest, 1 being the lowest)

How much pain are you currently dealing with chronically on a scale of 1-10? (10 being the highest pain level, 1 being the lowest pain level)

How fulfilled are you in your life currently on a scale from 1-10? (10 being the most fulfilled, 1 being the least fulfilled)

**Sleep Quality**

On average, what time do you generally go to sleep?

On average, what time do you generally wake up?

On average, how many hours do you sleep per night?

On average, how many times do you wake during the night?

Please list any medications, supplements, or substances (alcohol, marijuana, etc,) to help you sleep at night?

On a scale of 1-10 (10 being the most difficult, 1 being the least difficult) how difficult is it for you to fall asleep at night?

On a scale of 1-10 (10 being the most difficult, 1 being the least difficult) how difficult is it for you to wake in the morning?

On a scale of 1-10 (10 being the high quality, 1 being low quality), what would you say your average sleep quality is?

Do you tend to wake up early in the morning regardless of the time that you go to sleep?

Do you toss and turn throughout the night?

Do you wake up in the middle of the night with anxiety, night sweats, or hunger? If yes, please indicate which symptom(s) you wake up with.

Is chronic pain impairing your sleep?

Do you have a history of sleep apnea? If yes, are you using a CPAP?

Do you drink coffee after 2PM?

Do you use any screens prior to sleep at night? Do you use the screens with red shift before bed?

What time do you typically exercise in the day?

**Appetite & Diet**

How would you describe your appetite in the morning on a scale of 1-10? (10 being the best, 1 being the worst)

How would you describe your appetite at lunch on a scale of 1-10? (10 being the best, 1 being the worst)

How would you describe your appetite in the evening on a scale of 1-10? (10 being the best, 1 being the worst)

How would you rate the overall “healthiness” of your diet on a scale of 1-10? (10 being the best, 1 being the worst). Think about the amount of nutrient dense fruits, vegetables, and animal foods you eat. Think about the amount of times you eat out, the amount of processed foods you eat, etc.

Please indicate the types of foods you crave and list the specific foods you use to meet those cravings below.

* 1. Salty:
  2. Sweet:
  3. Fatty:
  4. Savory:

On average, how many meals do you typically eat in a day?

On average, how many snacks do you typically eat in a day?

Do you frequently snack rather than having full meals?

On average, how many alcoholic drinks do you have per week?

Do you smoke? If yes, how many packs per week do you smoke?

On average, how many meals do you typically eat out each week?

What meals do you typically have the least amount of time to prep for?

**Allergies and Sensitivities** (Please list any allergies or sensitivities)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

**Most Pressing Symptoms** (Please list your most pressing symptoms):

1.

2.

3.

4.

5.

**General Symptoms** (Please put an “X” next to, highlight, or circle all symptoms that apply to you):

**1) Neurological**

* ADD/ADHD
* Brain fog
* Carpal tunnel
* General dizziness
* Dizziness upon standing
* Epilepsy
* Eye twitches
* Headaches
* Insomnia
* Migraines
* Muscle pain along spine
* Narcolepsy
* Neuralgia
* Neuropathy
* Numbness
* Paralysis
* Sciatica
* TIA’s
* Tics
* Tingling
* Tremors
* Trigeminal neuralgia
* Visual changes
* Other (please specify below)

**2) Cognitive**

* Addiction (please specify what you are addicted to)
* Excess anger; hot blooded
* Anxiety
* Apathy
* Confusion
* Depression
* Diagnosed mood/ psychiatric disorder (please specify which disorder)
* Eating disorder
* Low motivation but normal energy
* Overly emotional
* Energy to do things but able to relax
* Fatigue
* Feeling wired
* Mania
* Mood swings
* Paranoia
* Pessimistic
* Phobias
* Racing thoughts
* Ready for any challenge that comes your way
* Relaxed
* Stressed
* Unable to relax, can’t sit still
* Want to recede into your own space and be left alone

**3) Dental**

* Aphthous ulcers
* Coated tongue
* Cracking/ dry lips
* Dentures
* Dry mouth
* Frequent canker sores
* Frequent cavities
* Frequent cold sores
* Gum disease
* Gum recession
* Mercury fillings
* Missing teeth
* Other fillings
* Titanium implants
* Root canals
* Toothache
* TMJ

**4) Ears, Nose, Throat**

* Deviated septum
* Difficulty swallowing
* Dizziness
* Constant ear infections
* Hearing loss
* Loss of smell
* Mouth breathing
* Mouth sores
* Nosebleeds
* Sinus congestion
* Sleep apnea
* Sore throat
* Stuffy nose
* Tinnitus
* Vertigo

**5) Endocrine**

* Always warm
* Slow to get going in the morning
* Difficulty relaxing
* Dizziness when standing up suddenly
* Crave salty foods
* Crave sweet foods
* Excessive urination
* Excessive hunger
* Chronic fatigue
* Can’t even get off the couch
* Cold easily
* Cold hands and feet
* Energy at night but tired during the day
* Excessive sweating
* Excessively heightened libido
* Decreased libido
* Excessive thirst
* Weight gain around the hips or waist
* Tendency to ulcers or colitis
* Heightened sensitivity to smells/ sounds
* Hot flashes
* Low energy
* Low motivation but normal energy
* Night sweats
* Tired after eating
* Tired upon waking
* Adult acne
* Difficulty gaining weight even with a large appetite
* Nervousness
* Fast pulse at rest
* Intolerance to heat
* Intolerance to cold
* Difficulty losing weight
* Mental sluggishness
* Easily fatigued
* Chronic constipation
* Loss of eyebrows
* Seasonal fatigue or depression
* Awaken a few hours after falling asleep, hard to get back to sleep
* Fatigue relieved by eating
* Sleepy in the afternoon
* Irritable before meals
* Shakiness if meals are delayed
* Headaches if meals are skipped or delayed

6) Immune

* + Runny nose
  + Mold exposure
  + Easily catch colds
  + Asthma
  + Seasonal allergies
  + Mucous producing cough
  + Frequent infections (check all that apply):
    - Cold
    - Sinus
    - Ear
    - Lung
    - Skin
    - Bladder
    - Kidney
  + Never get sick
  + Cysts
  + Boils
  + Rashes
  + History of (check all that apply):
    - Mono
    - Epstein Bar
    - Herpes
    - Shingles
    - Chronic fatigue
    - Fibromyalgia
    - Hepatitis

7**) Cardiovascular**

* Arrhythmia’s
* High blood pressure
* Elevated cholesterol
* Elevated heart rate
* Decreased heart rate
* Palpitations
* Raynaud’s
* Heavy or irregular breathing
* Shortness of breath with moderate exertion
* Ankles swelling at the end of the day
* Cough at night
* Muscle cramps in the lower legs with exertion
* Chest pain with exertion

8**) Respiratory**

* Asthma
* Emphysema
* Bronchitis
* Frequent upper respiratory infections
* Productive cough
* Dry cough
* Current smoker
* Former smoker
* Prone to pneumonia
* Prone to seasonal flus
* Shortness of breath
* Oxygen use

9**) Upper GI**

* Belching or gas within one hour after eating
* Frequent burping
* Bloating within 1 hour after eating
* Heart burn or acid reflux
* GERD
* History of vegan dieting
* Bad breath
* Loss of taste for meat
* Stomach upset by vitamins
* Sense of excess fullness after meals
* Fingernails chip, peel, or break easily
* Anemia that is unresponsive to iron
* Stomach pains or cramps
* Black or tarry colored stools
* Undigested food in stool
* Pressure around stomach area
* Tightness in the abdomen
* Stomach ulcers

**10) Liver & Gallbladder**

* + Pain between shoulder blades
* Stomach upset by greasy foods
* Greasy or shiny stools
* Nausea
* History of morning sickness
* Light colored or clay colored stools
* Dry skin, itchy skin, or skin peeling to the feet
* Gallbladder attacks
* Gallbladder removed
* Gallstones
* Bitter taste in mouth after meals
* Become sick when drinking wine
* Easily intoxicated when drinking wine
* Easily hung over when drinking wine
* History of alcohol abuse
* History of hepatitis
* Sensitive to chemicals
* Pain under right rib cage
* Hemorrhoids or varicose veins
* Pressure in mid to lower abdomen

11) Small Intestine

* + Food allergies
  + Bloating 1 to 2 hours after eating
  + Specific foods make you tired or bloated
  + Hives after eating
  + Sinus congestion after eating
  + Alternating constipation and diarrhea
  + Crohn’s disease
  + Wheat or grain sensitivity
  + Dairy sensitivity
  + Use of NSAID’s
  + Brain fog after eating
  + Mucous production after meals
  + Excess flatulence
  + Cramping
  + Constipation
  + Diarrhea
  + IBS

12) Large Intestine

* + Anus itching
  + Coated tongue
  + Antibiotic use
  + Fungus or yeast infections
  + Ring worm
  + Jock itch
  + Athletes foot
  + Nail fungus
  + Difficult or hard to pass stools
  + History of parasites
  + Less than one bowel movement per day
  + Loose stools
  + Mucous in stool
  + Blood in stool
  + Bad breath or strong body odor
  + Dark circles under eyes
  + Cramping in left lower area of abdomen
  + Excessive foul smelling gas
  + Bright red blood in stool

13) Vitamin & Mineral Needs

* + History of stress fracture
  + Bone loss evidenced by bone scan
  + Calf/ foot or toe cramps at rest
  + Frequent cold sores or herpes lesions
  + Frequent skin rashes and/or hives
  + Craving ice
  + Craving chocolate
  + History of anemia
  + White spots on fingernails
  + Bleeding to the corners of the mouth
  + Slow healing of wounds
  + Easy scaring
  + Decreased sense of taste or smell
  + Muscles become easily fatigued
  + Feel exhausted or sore after moderate exercise
  + Loss of muscle tone, heaviness in arms/ legs
  + Enlarged heart or congestive heart failure
  + Numbness, tingling, or itching in the hands and/ or feet
  + Nervous or agitated
  + Night sweats
  + Fragile skin
  + Restless leg syndrome
  + Small bumps on the back of the arms
  + Difficult seeing at night
  + Nose bleeds or tend to bruise easily
  + Bleeding gums, especially when brushing teeth

14**) Skin**

* Acne
* Blisters
* Boils "spider bites"
* Brittle nails
* Bruise easily
* Cellulitis
* Dry skin
* Eczema
* Edema
* Fungal infections
* Hair loss
* Hair thinning
* Itching
* Oily skin
* Psoriasis
* Skin abrasion
* Skin lesions
* Rash

**15) Musculoskeletal**

* Disc degeneration
* Disc herniation
* Excessively flexible joints
* Joints pop or click
* Pain and swelling to the joints
* Fibromyalgia
* Osteoarthritis
* Osteopenia
* Pain
* Spinal stenosis
* Sprain / strain
* Tendinitis or bursitis
* Tension / soreness
* Muscle tightness
* Lower back pain
* Neck pain
* Shoulder pain
* Knee pain
* Other aches & pains (please list):

**16) Female Reproductive**

* Absence of menstruation
* Copper implant (IUD)
* Cramps
* Excessive bleeding during menstruation
* Frequent yeast infections
* Hormonal implant (IUD)
* Inability to stay lubricated during sex
* Painful intercourse
* Infertility
* Irregular menstruation
* Loss of libido
* Menopause
* Menstrual depression
* Excessive menstrual flow
* Occasional skipped periods
* Endometriosis
* Uterine fibroids
* Miscarriage
* Mood swings
* Painful intercourse
* Past use of birth control
* Pelvic pain
* PMS
* Breast tenderness with cycle
* Present use of birth control
* Uterine fibroids
* Vaginal bleeding
* Vaginal discharge
* Vaginal dryness
* Vaginal itchiness
* Excess facial or body hair
* Hot flashes

**17) Urogenital**

* 5 alpha reductase inhibitor (finasteride, dutasteride) induced sexual dysfunction
* SSRI induced sexual dysfunction
* Blood in semen
* Blood in urine
* Erectile dysfunction
* Excessive or irregular fatigue after ejaculation
* Frequent masturbation with use of porn
* Genital discharge
* Impotence
* Inability to maintain erection during sex
* Inability to orgasm
* Loss of "morning wood"
* Loss of libido
* Pain during sex
* Painful ejaculation
* Painful urination
* Past use of anabolic steroids or SARMS
* Performance anxiety
* Premature ejaculation
* Present use of anabolic steroids or SARMS
* Prostate issues
* SSRI related sexual dysfunction
* Frequent urination at night
* Urinary frequency
* Urinary incontinence
* Urinary retention
* Urinary tract infections
* Urinary urgency
* Varicocele
* History of kidney stones
* Urine has strong odor
* Darkened urine
* Pain in the mid to lower back

**18) Previously Used Medications** (Please indicate any medications that you have previously used)

* + Proton pump inhibitors (Omeprazole/ Lansoprazole/ etc.)
  + Benzodiazepines (Xanax/ Ativan/ etc.)
  + Sleeping medications (Ambien/ Trazodone/ Ramelteon/ etc.)
  + Flouroquinolone antibiotics (Ciprofloxacin/ Levofloxacin/ etc.)
  + Metronidazole (Flagyl)
  + Other antibiotics (Amoxicillin/ Doxycyline/ Bactrim/ etc.)
  + Accutane
  + NSAIDs, except aspirin (Ibuprofen/ Naproxen/ Celecoxib/ etc.)
  + Acetaminophen
  + Aspirin
  + Anti-fungals (Fluconazole/ Terbinafine/ Nystatin)
  + Oral birth control
  + Implantable birth control
  + Injectable birth control
  + Synthetic hormonal replacement therapy (Ethinyl estradiol/ Medroxyprogesterone acetate)
  + Corticosteroids (Cortisone/ Dexamethasone/ Betametasone/ etc.)
  + Testosterone (Test. Cypionate/ Test. Enanthanate/ Test. Decanoate/ etc.)
  + Synthetic anabolic/ androgenic steroids
  + Thyroid medication (NDT/ Levothyroxine/ Liiothyronine/ etc.)
  + Antidepressants (Sertraline/ Fluoxetine/ Citalopram/ etc.)
  + Anticonvulsants (Carbamazepine/ Leviracetam/ Valproic acid/ etc.)
  + Chemotherapy
  + Cholesterol lowering medications (statins/ PCSK9 inhibitors/ Ezetimibe/ etc.)
  + Diabetic medications, except insulin (Metformin/ Glipizide/ etc.)
  + GLP-1 drugs (Semaglutide/ Liraglutide/ Exanetide/ etc.)
  + Insulin
  + Diuretics (spirinolactone/ HCTZ/ Furosemide/ etc.)
  + Blood pressure medications (Amlodipine/ Losartan/ Lisinopril/ etc.)
  + Recreation drugs (Marijuana/ Cocaine/ DMT/ etc.)
  + Opiate medications (Oxycodone/ Fentanyl/ Morphine/ Hydropmorphone/ etc.)
  + Heart medications (Mexitil/ Fleicanide/ etc.)
  + 5-Alpha-Reductase inhibitors (Dutasteride/ Finasteride)