Health History Form

# PERSONAL INFORMATION

Full Name: Date of Birth: Age:

Sex Assigned at Birth: Gender Identity: Pronouns:

Occupation:

Email:

Phone:

Home Address:

Preferred Contact Method:

* Phone
* Text
* Email
* Mail

Emergency Contact Name:

Relationship: Phone:

# HEALTH AND WELLNESS GOALS

What are your primary health and wellness goals? Why are they important to you?

# PERSONAL HEALTH AND MEDICAL HISTORY

# Health Information

What’s the most important thing you’d like to share about your health story?

Primary care provider:

Other Healthcare Providers (specialists, therapists, etc.):

Current Medications & Supplements:

Barriers to Healthcare Access (if any):

# MedicalInformation

Medical Conditions, Diagnoses, or Significant Health Events (illnesses, surgeries, injuries, etc.):

# Family History

Family Health History (Parents, Siblings):

* Mother's Health:
* Father’s Health:

Other Notable Family Health Information:

# PHYSICAL HEALTH INFORMATION

Current Weight: Height:

# Sleep**:**

* How many hours do you sleep per night on average?
* How would you describe your quality of sleep? ☐ Poor ☐ Fair ☐ Good ☐ Excellent
* Pain, Stiffness, or Swelling? (If yes, explain):

How Digestive Health Concerns:

☐ Bloating

☐ Nausea

☐ Constipation

☐ Diarrhea

☐ Other: \_\_\_\_\_\_\_\_\_\_\_

 Hormonal & Reproductive Health Concerns:

 ☐ Irregular Cycle

 ☐ Low Libido

 ☐ Thyroid Issues

 ☐ Other: \_\_\_\_\_\_\_\_\_\_\_

 Immune & Allergies:

 ☐ Autoimmune Conditions

 ☐ Frequent Infections

 ☐ Allergies (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brain & Cognitive Health:

☐ Brain Fog

☐ Difficulty Concentrating

☐ Forgetfulness

☐ Other: \_\_\_\_\_\_\_\_\_\_\_

# NUTRITION INFORMATION

What foods did you grow up eating?

How would you describe your past relationship with food?

Describe your current relationship with food.

Do you have any food allergies or intolerances? If so, please list:

Do any of the following apply to you? (Check all that apply.)

* Challenges with Preparing Meals
* Difficulties Chewing or Swallowing
* Challenges with Access to Food
* Poor Appetite

Do you regularly use any of the following? (Check all that apply.)

* Alcohol
* Tobacco Products
* Other Substances:

Do you follow a specific eating approach/practice for personal, health, or religious reasons (e.g., vegan, ketogenic, kosher)? If so, please explain:

What does a typical day of eating look like for you? List a few foods/meals and drinks you usually consume in the corresponding categories:

Lunch

|  |  |
| --- | --- |
| **Breakfast** | **Lunch** |
|  |  |

|  |  |
| --- | --- |
| **Dinner** | **Snacks** |
|  |  |

What, if anything, would you like to change about your nutrition?

# MENTAL AND EMOTIONAL HEALTH INFORMATION

How would you describe your overall mental and emotional health?

How do you support your mental well-being?

How do you manage stress?

Using a 1–5 scale (where 1 = never and 5 = always), rate how often you experience each of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anger  | Excitement  | Fear  | Joy  | Love  |
| Sadness  | Stress  | Worry  |  |  |

# SPIRITUAL HEALTH INFORMATION

What role does spirituality play in your life, if any?

# LIFESTYLE INFORMATION

What are the important relationships in your life?

Is there anything you’d like to share about your social life? If so, please explain:

Who do you live with, if anyone?

How many hours per week do you typically work?

What hobbies or recreational activities do you enjoy?

How often do you engage in movement/exercise? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never

# ADDITIONAL COMMENTS

Is there anything else you’d like to share about your health and well-being