

***Adult Health History***

Please answer all applicable questions to the best of your knowledge. We look forward to working with you.

Client Name: Age: Date of Birth:

Occupation: Employer: Work Hours/Week:

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ With Partner ❑ Widower

Do you have children? ❑ Y ❑ N If ‘yes,’ how many?

Highest Level of Education: ❑ High School ❑ Some College ❑ College Graduate ❑ Graduate School

Insurance Company: Policy: Group #:

Name of Insured: Relation to Insured:

Social Security Number:

Person to call in case of Emergency: Relationship:

Emergency Contact Phone Number: ( )

Regular Physician: Phone Number: ( )

How Did You Hear About Us? ❑ Referral ❑ Web Search ❑ Email ❑ Facebook ❑ Advertisement ❑ Event

Other -

CURRENT HEALTH PICTURE

What are your main health concerns/reasons for your visit? (Please List in Order of Importance)

1. Date First Noticed or Diagnosed:

2. Date First Noticed or Diagnosed:

3. Date First Noticed or Diagnosed:

4. Date First Noticed or Diagnosed:

5. Date First Noticed or Diagnosed:

Please list any Additional Questions or Expectations of the appointment today.

The general state of your health is (please circle one): ❑ Excellent ❑ Good ❑ Average ❑ Fair ❑ Poor

Are you currently seeing (a) medical specialist (s)? ❑ Y ❑ N If yes, for what reason?

When was the last time you had blood work or other lab testing performed?(month/year):

What type of testing was performed?:

Is this your first time working with a Holistic Nutritionist for any of your main health concerns? ❑ Y ❑ N

Family History

Father Mother Siblings Grandparents Spouse Children

Age if living

Age when died

Reason for death

Cancer (any type) ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N

High Blood Pressure ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N Heart Attack/Stroke ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N

Heart Disease ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N Asthma/Allergies ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N

Mental illness ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N Drug or Alcohol Addiction ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N

Auto-immune disease ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N

Diabetes Mellitus ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N

Osteoporosis ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N ❑Y ❑N

List any other pertinent family information in the space below:

4 Considerations – Scar Tissue

**List All Surgeries and Reasons for Hospitalizations (Include any cosmetic procedures):**

1. Date: 2. Date:

3. Date: 4. Date:

5. Date: 6. Date:

**List All Accidents, Injuries, or Physical Traumas:**

1. Date: 2. Date:

3. Date: 4. Date:

5. Date: 6. Date:

**Please Note When and Why You Had Each of The Following:**

X-rays:

MRI/Cat Scans:

Ultrasounds:

4 Considerations – Acidic pH

**Please Mark Any of the Following You Feel Apply to You:**

❑ dark circles under the eyes ❑ acne ❑ eczema ❑ history of asthma/sinusitis ❑ history of hernias

❑ history of irritable or inflammatory bowel ❑ history of acid reflux ❑ history of migraines

❑ history of ear itching/infections ❑ fatigue 2+ hours after eating ❑ itchy eyes ❑ nosebleeds

❑ sore throat/stiff neck

**Please List All Sensitivities/Allergies/Reactions:**

Drugs:

Foods:

Environmental:

❑ red eyes ❑ sensitive skin ❑ myxedema ❑ zinc spots on nails ❑ brittle nails/hair ❑ multiple broken bones ❑ clear urine ❑ arthritis ❑ easy bruising ❑ slow reflexes/recall ❑ cavities ❑ high blood pressure

❑ low blood pressure ❑ heart palpitations ❑ kidney stones

❑ constipation ❑ clay colored stools ❑ diarrhea ❑ nausea ❑ vomiting ❑ acid reflux ❑ hemorrhoids

❑ hernias ❑ flatulence ❑ rectal bleeding ❑ rectal itching ❑ history of ulcers ❑ mucus in stools

❑ alternating diarrhea & constipation ❑ undigested food in stools

List All Travel Outside of the US Over Last 5 Year?

Have you consumed any untreated river water while hiking or camping? ❑Y ❑N

Have you ever done a Colon or Liver Cleanse? ❑Y ❑N If ‘yes,’ when was your last one?

Have you ever fasted? ❑Y ❑N If ‘yes,’ when was your last one?

How many rounds of antibiotics have you had within the last year? 5 years? Lifetime?

**List Yes, No, or Past regarding use of the following:**

Antacids: ❑Y ❑N ❑P Laxatives: ❑Y ❑N ❑P

Analgesics: ❑Y ❑N ❑P Steroids: ❑Y ❑N ❑P

Recreational drugs: ❑Y ❑N ❑P Any drug treatment: ❑Y ❑N ❑P

Cigarettes: ❑Y ❑N ❑P Packs per day:

Marijuana: ❑Y ❑N ❑ Days per week:

Alcohol: ❑Y ❑N ❑P Days per week:

Coffee: ❑Y ❑N ❑P Cups per day:

Soda Pop: ❑Y ❑N ❑P Ounces per day:

**Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):**

Measles: ❑D ❑I ❑N Diphtheria: ❑D ❑I ❑N

Mumps: ❑D ❑I ❑N Tetanus: ❑D ❑I ❑N

Rubella: ❑D ❑I ❑N Whooping Cough: ❑D ❑I ❑N

Chickenpox: ❑D ❑I ❑N Hemophilus (Hib): ❑D ❑I ❑N

German Measles: ❑D ❑I ❑N Hepatitis B: ❑D ❑I ❑N

Any vaccination reactions:

**Medications: Please give full name, dosage, and length of time that you have been taking medication**

Pharmaceuticals Dose When/ How often

Supplements/Herbs Dose When/ How often

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:

Have you ever experienced shortness of breath, memory fog, fainting, or any peculiar symptoms after installing new carpet, paint, furnishings, or any other home refurbishing?:

Are you particularly sensitive to perfumes, gasoline, or other vapors?:

Do you use pesticides, herbicides, other chemicals around your home?

How many amalgam ‘silver’ filings do you have?

Perspiration has Odor: ❑ Y ❑ N

4 Considerations – Emotional Charge

**Please Mark Any of the Following You Feel Apply to You:**

❑ unworthy ❑ resistant to change ❑ accepting of defeat ❑ busy as escape ❑ excessive concentration

❑ mental chatter ❑ easily overwhelmed ❑ grieving ❑ keeping it inside ❑ can’t let go ❑ lack of trust

❑ afraid/worried/anxious ❑ angry ❑ indecisive ❑ frustrated/impatient ❑ complaining ❑ timid ❑ alone

❑ isolated ❑ neglected ❑ guilt ❑blaming ❑ excessive thought/second guessing self

Have you ever been witness to or subjected to acts of physical violence, abuse or emotional trauma? ❑ Y ❑ N

If ‘yes’ please list at what age(s)?

Have you ever been in a serious accident or injured in life-threatening situation? ❑ Y ❑ N

If ‘yes’ please list at what age(s)?

**Stress History: Please list the 5 most significant, stressful events/relationships/situations in your life.**

1. Date
2. Date
3. Date
4. Date
5. Date

How many hours do you sleep each night? How long does it take you to get to sleep?

Do you sleep through the night uninterrupted? ❑ Y ❑ N Do You Dream? ❑ Y ❑ N

If you wake, what is the time & reason:

Nightmares: ❑ Y ❑ N Do you wake feeling refreshed? ❑ Y ❑ N

Grind Teeth: ❑ Y ❑ N Do you Snore? ❑ Y ❑ N

Present Weight: lbs Weight One Year Ago: lbs Ideal Weight: lbs

Maximum weight as adult and when: Minimum Weight as adult and when:

Height: ft in

On average, describe your energy level from 1-10 Waking? Evening? (10 = high, 1 = very low energy)

On average, describe your happiness level from 1-10? (10 = very, very happy)

Average Number of Bowel Movements per Day? Number of Days Each Week without a BM?

Regularly Feel Energetic: ❑ Y ❑ N

Regularly Feel Fatigue: ❑ Y ❑ N

If you have fatigue, when is it the worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ After Eating

If you have fatigue, can you do what you need to during the day (ie for work/family)? ❑ Y ❑ N

4 Considerations – Biomechanical Misalignment

❑ back pain ❑ shoulder pain ❑ neck pain ❑ sciatica ❑ carpal tunnel syndrome ❑ TMJ syndrome

❑ numbness ❑ tingling ❑ seizures ❑ muscle pain that moves from place to place

How often do you Practice Yoga or some alternate form of therapeutic stretching? Days per Week

How often do you use Cardiovascular Exercise? Days per Week. For How Long? Minutes

How often do you get massaged? Times Per Month

General History

Sexually Active: ❑ Y ❑ N

Healthy Libido: ❑ Y ❑ N

Sexually Satisfied: ❑ Y ❑ N

What Hobbies/Interest Bring You The Most Happiness?

Are you working with a professional counselor, psychologist, social worker, pastor, or other therapist? ❑ Y ❑ N

Are you happy with your spiritual practice? ❑ Y ❑ N Active? ❑ Y ❑ N

Do you enjoy your job? ❑ Y ❑ N



# If Applicable - Female Reproductive:

Do You Know How to Identify Genital Warts on your partner? ❑ Y ❑ N

If Menopausal at what age did it occur?

Times Pregnant: How many births: Miscarriages: Abortions:

Any Difficulty Getting Pregnant? ❑ Y ❑ N

Age periods began: Periods occur every: days

Periods last: days

Are her periods? ❑ regular(4-6 days) ❑ long ❑ short ❑ none

Menstrual Flow? ❑ regular ❑ heavy ❑ scant

What color is the blood? ❑Light ❑ Medium ❑ Dark Red

Spotting or bleeding in between periods? ❑ Y ❑ N

Has she noticed clots? ❑ Y ❑ N Food Cravings: ❑ Y ❑ N

Cramping: ❑ Y ❑ N Pain: ❑ Y ❑ N

PMS: ❑ Y ❑ N Pelvic Pain: ❑ Y ❑ N

PMS Symptoms where relevant:

❑ Water Retention ❑ Breast Tenderness ❑ Irritability ❑ Headaches ❑ Depression ❑ Mood Swings

Do you perform monthly Self-Breast Exams? ❑ Y ❑ N

Last Pap Smear: Pain With Intercourse: ❑ Y ❑ N

Diagnosis: Dry Vagina: ❑ Y ❑ N

Vaginitis: ❑ Y ❑ N

**I understand that the extent to which my health goals are successful will be determined by the amount of**

**energy, commitment, and dedication I give to support the work I am endeavoring into.**

**I accept responsibility for my health.**

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