BACK TO BASICS HEALTH & NUTRITION

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing *Back To Basics Health & Nutrition* to assist you with your natural health care. The ability to draw effective conclusions about your state of health and how to optimize its improvement may be influenced by many factors. The information from this form will assist to provide you with an optimal plan of health care.

Date _____

First Name _____ Middle _____ Last_____

Address _____ City _____ State _____ Zip Code_____

Home Phone (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Email _____ Age _____ Date of Birth _____/_____/_____

Gender: ❑ Female ❑ Male

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Long Term Partnership

Genetic Background – please check appropriate box(es):

❑ Caucasian ❑ Native American ❑ African American ❑ Hispanic ❑ Mediterranean ❑ Asian

❑ Other _____

Occupation _____ Hours per week _____

Nature of Business _____

_____

_____

Emergency Contact: _____ Phone _____

Name, address, & phone number of primary care physician:_____

_____

_____

SYMPTOMS AND AREAS OF CONCERN Please check all that apply.

- ❑ Acne
- ❑ ADD/ADHD
- ❑ Adrenal Glands
- ❑ Allergies
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Anger
- ❑ Anxiety
- ❑ Appetite
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Bad Breath
- ❑ Bed Wetting
- ❑ Bell's Palsy
- ❑ Bites
- ❑ Bladder
- ❑ Blood Pressure - High
- ❑ Blood Pressure - Low
- ❑ Boils
- ❑ Bones
- ❑ Breathing
- ❑ Bronchitis
- ❑ Bruises
- ❑ Burns
- ❑ Cancer
- ❑ Candida
- ❑ Canker Sores
- ❑ Carpal Tunnel
- ❑ Cataracts
- ❑ Chest Congestion
- ❑ Chest Pain
- ❑ Cholesterol
- ❑ Circulation
- ❑ Cold - Common
- ❑ Cold - Temperature
- ❑ Colic
- ❑ Colon
- ❑ Constipation
- ❑ Cough
- ❑ Cravings
- ❑ Dandruff
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Digestion
- ❑ Dizzy Spells
- ❑ Ear Infection
- ❑ Ear Ringing
- ❑ Edema
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Eyesight
- ❑ Fatigue
- ❑ Fever
- ❑ Flu
- ❑ Gallstones
- ❑ Gangrene
- ❑ Gas
- ❑ Gout
- ❑ Gums
- ❑ Hair Issues
- ❑ Headache
- ❑ Heart Issues
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Herpes
- ❑ Hiatal Hernia
- ❑ Hives
- ❑ Hormones
- ❑ Hyperactive
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypoglycemia
- ❑ Impotence
- ❑ Incontinence
- ❑ Indigestion
- ❑ Insomnia
- ❑ Joint Pain
- ❑ Kidney Issues
- ❑ Kidney Stones
- ❑ Laryngitis
- ❑ Leprosy
- ❑ Leukemia
- ❑ Liver
- ❑ Lung Issues
- ❑ Lupus
- ❑ Lymph Glands
- ❑ Menopause
- ❑ Menstrual Cramps
- ❑ Migraines
- ❑ Mononucleosis
- ❑ Mucous
- ❑ Nails
- ❑ Nausea
- ❑ Nervousness
- ❑ Nose Bleeds
- ❑ Parasites
- ❑ Parkinson's Disease
- ❑ Perspiration
- ❑ PMS
- ❑ Pneumonia
- ❑ Polyps
- ❑ Pregnancy
- ❑ Prostate
- ❑ Psoriasis
- ❑ Rash
- ❑ Reproductive
- ❑ Respiratory
- ❑ Rheumatism
- ❑ Ring Worm
- ❑ Seizures
- ❑ Shingles
- ❑ Sinus
- ❑ Skin Issues
- ❑ Snoring
- ❑ Sore Throat
- ❑ Stomach
- ❑ Stress
- ❑ Stroke
- ❑ Sty
- ❑ Teething
- ❑ Tennis Elbow
- ❑ Tonsillitis
- ❑ Tumors
- ❑ Ulcers
- ❑ Urinary Infections
- ❑ Varicose Veins
- ❑ Vertigo
- ❑ Weight
- ❑ Yeast Infections

Other Symptoms/Concerns _____

_____

SYMPTOMS AND AREAS OF CONCERN (continued)

What medical diagnosis or explanation(s), if any, have been given to you for these symptoms/concerns?

_____

_____

What physician or health care providers (alternative practitioners) have you seen for these conditions?

_____

_____

MEDICATIONS

List all medications – include all over the counter non-prescription drugs.			
Medication Name	**Date Started**	**Date Stopped**	**Dosage**

List all vitamins, minerals, and any nutritional supplements that you are taking now.			
Type	**Date Started**	**Date Stopped**	**Dosage**

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? ❑ Yes ❑ No

If yes, please list: _____

_____

NUTRITIONAL

Do you currently follow a special diet or nutritional program? ❑ Yes ❑ No

Are you any of the following:

❑ Paleo ❑ Diabetic ❑ Dairy Restricted ❑ Vegetarian ❑ Vegan ❑ Blood Type Diet ❑ Keto

❑ Other (describe) _____

Is there is anything special about your diet:

_____

Do you have symptoms immediately after eating, such as belching, bloating, hives, etc? ❑ Yes ❑ No

If yes, are these symptoms with a particular food or supplement? _____

Does skipping meals greatly affect you? ❑ Yes ❑ No

Do you have an aversion to certain foods? ❑ Yes ❑ No

If yes, what food(s) _____

What foods do you crave?_____

How much of the following do you consume? (1D=once daily, 2W=twice a week, 3M=three times a month)

Soda Pop _____	Coffee _____	Smoking _____	Alcoholic Bev _____
Fast Food _____	Milk _____	White Flour _____	Sugar Usage _____
Raw Fruit _____	Meat _____	Raw Veggies _____	Whole Grains _____

LIFESTYLE

Do you smoke? ❑ Yes ❑ No

If yes, how much? _____

Are you exposed to 2nd hand smoke regularly? ❑ Yes ❑ No

If yes, please explain:_____

_____

Average number of hours that you sleep at night? ❑ less than 6 ❑ 6-8 ❑ 8-10 ❑ more than 10

LIFESTYLE (continued)

Do you exercise regularly? ❑ Yes ❑ No

If yes, please indicate: Type of exercise	Times/Week				Length of Session			
	1x	2x	3x	4x/+	≤15 min	16-30 min	31-45 min	>45 min
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please list below) _____								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc.)

_____

What are your top 3 health concerns?

Who referred you for your appointment today? _____

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and this is a personal ministry and spiritual counseling.

I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not on this visit or any subsequent visit an agent for federal, state, or local agencies or on a mission of entrapment or investigation.

The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health and do not involve the diagnosing, treatment, or prescribing of remedies for disease.

Signature_____ Date_____