PERSONAL HEALTH EVALUATION

Personal Information

Name _____ Date _____

Address _____

_____

Phone _____ Email _____ Referred by _____

Occupation _____ DOB _____ Sex ____ Height _____ Weight _____

II Diet, Nutrition and General Health Practices

a. How often do you consume the following? (1 = Very Frequently, 2 = Often, 3 = Rarely, 4 = Never)

Refined Sugar	1 2 3 4	Dairy Products	1 2 3 4	Fresh Fruits	1 2 3 4
White Flour	1 2 3 4	Pork/Shellfish	1 2 3 4	Vegetables	1 2 3 4
Alcohol	1 2 3 4	Red Meat	1 2 3 4	Green Salads	1 2 3 4
Fried Foods	1 2 3 4	Chicken/Turkey	1 2 3 4	Whole Grains	1 2 3 4
Caffeine Drinks	1 2 3 4	Artificial Sweeteners	1 2 3 4	Fresh Fish	1 2 3 4

b. How much water do you drink each day? _____ Ounces
What kind of water do you drink? _____

c. How much sleep do you get each night on the average? _____ Hours
How do you sleep?

d. What is your energy level like?

e. How many meals per day do you eat?

f. How often do your bowels eliminate?

g. Do you feel like you are under stress? If so, explain.

h. What nutritional supplements are you currently taking?

III. Medical Information

a. What are your current health concerns?

b. List any serious illnesses or surgeries you have had in the past.

c. Are you under a medical doctor's care for your condition? _____
If so, what medications, drugs or therapies are you currently using?

d. What medications, medical procedures, supplements or therapies have you previously tried for your condition?
Were any of these supplements or therapies helpful? If so, please note which ones were helpful?

e. Additional comments or helpful information, if any.