

PERSONAL HEALTH HISTORY		
List any medical problems that doctors have diagnosed currently or in the past...		
Surgeries (if more than 3, use a separate sheet of paper)		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital
Dental History		
When was your last dental visit?		
How many fillings do you have in your mouth? If you know, how old are they, and what are they made of?		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Known allergies to foods and/or medications		
Name the food and/or medication	Reaction You Had	

Sleep	Are you happy with your sleep? YES NO
	How many hours of sleep do you get on a 'normal' night for you?
	How many hours of sleep do you <i>feel</i> /you need?
	What time do you go to bed?
	What time do you wake up?
	How long does it take you to fall asleep?
	Do you frequently need longer than 30 minutes to fall asleep? YES NO
	Do you frequently wake up in the middle of the night and have trouble falling back to sleep? YES NO
	Do you regularly watch the 9PM, 10PM, or 11PM news? YES NO
	How many times a week (if any) do you watch TV at night?
	Do you work or use a computer after 6 PM? YES NO
	Do you travel across more than 2 time zones more than once a month? YES NO
	Do you take prescription sleeping pills? If so, what kind and what dose?
	Do you use over-the-counter sleeping pills, such as Tylenol PM? If so, which brand and how often each week?
	Are you sleepy during the day? YES NO
	Do you nap? YES NO
	Do you use caffeine? If 'yes' at what times during the day? YES NO
	What form: coffee, tea, herbal pills, synthetic pills (like Vivarin or No-Doze)? If so, which ones?
Do you do your best work in the morning or later in the day?	
Do you snore or share the bed with someone who snores? YES NO	

Stress	Please rate your overall stress level: (no stress) 1 2 3 4 5 6 7 8 9 10 (extreme stress)
	Do you have children? If so, how many? YES NO
	What time do you go to bed?
	Are family relationships causing you a lot of stress? YES NO
	Do you suffer from anxiety more than once a week? YES NO
	Do you have trouble sitting still? YES NO
	Do you have trouble concentrating on tasks? YES NO
	Do you feel like your sex drive is low? YES NO
	Do you feel like your energy level is low? YES NO
	Are you often angry at others? YES NO
	Do you like your work? YES NO
	Do you have significant financial worries like heavy debt, business problems, etc? YES NO
	Do you presently take (or have taken within the last 2 years) medication for depression, anxiety, or other mood disorders? If so, please list them. YES NO
	Do you lose more than 5 work days a year due to illness? YES NO
	Do you find yourself turning to food or alcohol when stressed? YES NO
	Do you suffer from chronic pain? YES NO
	Do you suffer from headaches? YES NO
Do bright lights bother you? YES NO	
Is there someone in your life (spouse, parent, partner, etc) that will resist your attempts to make changes? YES NO	

Alcohol	Do you drink alcohol? YES NO
	If yes, what kind?
	How many drinks per week?
	Are you concerned about the amount you drink? YES NO
	Have you considered stopping? YES NO
	Have you ever experienced blackouts? YES NO
	Are you prone to "binge" drinking? YES NO
	Do you drive after drinking? YES NO

Tobacco	Do you use tobacco? YES NO			
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		

Drugs	Do you currently use recreational or performance enhancing drugs? YES NO
	If 'yes' please briefly explain.

Food, Water,	Do you (or does a family member) cook and prepare dinner at least 5 nights a week? YES NO			
	How often (meals per week) do you eat in restaurants / fast food joints?			
	Do you ever crave baked goods (breads, etc)?			
	How is your energy level after breakfast? High Low			
	How is your energy level after lunch? High Low			
	How is your energy level after dinner? High Low			
	Do you often snack? YES NO			
	Do you often feel tired about an hour after eating? YES NO			
	Do you eat dessert more than one night a week? YES NO			
	Approx. how many ounces or liters of water do you drink each day?			
	Is it filtered or purified water? YES NO			
	Digestion	Do you drink sodas (regular or diet) or sugared drinks, including 'sports drinks'? YES NO		
Do experience any of the following symptoms?				
Bloating		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Belching?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Gas?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Heartburn?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Gurgling noises in your belly?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Nausea?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Constipation?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Abdominal pain?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Headaches?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Diarrhea?		<input type="checkbox"/> Rarely / Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Frequently
Food "Habits"	Do you generally feel good after a meal? YES NO			
	Do you need to eat at night in order to fall asleep? YES NO			
	Do you often feel guilty after you eat? YES NO			
	Do you often eat even when you're not hungry? YES NO			
	Do you often think about food? YES NO			
	Do you lie about your eating habits? YES NO			
	Have you tried "fad diets" in the past? If so, which ones? YES NO			
	What 5 foods do you most often eat?			
1				
2				
3				
4				
5				

3 TYPICAL DAYS OF FOOD

Please list your last 3 breakfasts, Lunches, Dinners, desserts and snacks.

Please be as honest as you can, as this will help us start making some changes.

Breakfasts

Lunches

Dinners

Desserts

Snacks

MOVEMENT				
Movement	Do you presently exercise? If yes, describe what you currently do: YES NO			
	If not, what is your feeling about exercise: <input type="checkbox"/> Would like to. <input type="checkbox"/> Grudgingly willing to do it because I know I should. <input type="checkbox"/> Hate it.			
	How many days per week would you be willing to do 30 –60 minutes of exercise?			
	Any significant injuries or physical limitations? YES NO			
	Back Pain? YES NO			
	Neck Pain YES NO			
	Shoulder Pain YES NO			
	Elbow Pain YES NO			
	Wrist pain YES NO			
	Hip or Knee Pain YES NO			
	Foot or ankle Pain? YES NO			
	Rate your feelings about the following activities			
	Weight training?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Yoga / tai chi / qi gong?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Running?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Walking / Hiking?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Bicycling?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Indoor cardio (classes / machines)?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Martial Arts / Boxing?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Skiing / snowboarding?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Tennis / Team Sports?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Swimming / Distance Racing?	<input type="checkbox"/> Unwilling to do it	<input type="checkbox"/> Don't do, but would	<input type="checkbox"/> Already do it
	Ever worked with a trainer before? YES NO			
	Are there particular activities/sports/races that you'd like to start participating in? If so, list them, please.			
	Any important events (wedding, vacation) that you'd like to lose weight for? If 'yes', please explain.			
	What is your athletic history (sports / activities you've been involved in)?			

Check if you have, or have had, any symptoms in the following areas (not covered in the previous pages) and briefly explain in the space below.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation

Please explain any checked boxes above.

Is there anything else you'd like me to know? For example, past car accidents, things you're concerned about, etc.