Health History Form
www.BiteSizePieces.net

Email: faces@vail.net

Client Name:_____

Street Address City State: Zip:_____
_____
Cell phone # with Area Code:

Your Email:

Age: ___ Place of Birth: _____

Weight six months ago?__ Weight one year ago? _____
Would you like your weight to be different?
_____
Are you underweight?_____
Are you always dieting?_____

*Do you sleep well? _____ Do you wake up at night?_
At what time(s)? __ Are you tired all day?___
What are your stresses or Emotional issues?_____

_____
Do you stuff emotions?_____

Do you eat when you are upset?_____

_____

How much Water do you drink during the day?_____

What do you eat for breakfast?_____What time?_____
Please list good fats you consume._____

Do you ever go all day without eating?_____

Do you drink energy drinks?_____

Do you drink coffee -how much?_____

How much Sugar weekly?_____(Candy, soda, muffins, breads, Alcohol and more)

Are you exposed to chemicals in your place of business?

_____
What business are you in?_____

Do you have mercury fillings in your teeth?_____

Do you have sugar swings?_____
Are you moody?_____

How many hours a week do you work?_____

Do you have a TV or computer in your bedroom?

_____

Do you suffer from heat intolerances?_____

Do you have cravings?_____What do you crave?

Are you eating MSG,High Fructose Corn Syrup and/ or Aspartame?_____

_____(Please check all products in pantry, gum, breads,crackers, cereal bars, cereals, juices, sauces, salad dressing,soda, ketchup, teas.etc)

Who is in charge of the food shopping in your family?

_____

Do you consume boxed, canned or fast foods?

_____

How many times a week?_____

Do you eat Microwaved foods? _____How often?

_____

Do you use Fluoride (water, toothpaste or in medication)?

_____

Do you have allergies?_____

Do you have GERD or acid reflux?_____

Do you have osteoporosis? _____

Do you smoke cigarettes now? _____Did you ever smoke? _____ When did you stop?_____

Do you have Constipation / Diarrhea?_____ Gut Digestion Issues?_____

Do you eliminate Daily?_____

Do you eat dairy?_____

What brand of dish soap and laundry soap do you use? _____
What shampoo?_____
Are your nails brittle?_____Hair dry/oily?_____
Do you have joint pain?_____
How is your concentration or focus?_____

Do you eat corn and corn products?_____

Do you take any vitamins /medications/ aspirin/ NSAID's _____
**If so, please list all medications-include all over the counter drugs_____
_____
_____
_____
_____
Are there any Chiropractors, Doctors, helpers, healers, pets, or therapies with which you are involved? Please list all:
_____

Do you use sunscreen?_____Name_____

What role does exercise play in your life?_____ How often?
_____

Please List all snacks during the day_____

List all meal times~ day/night _____
What percentage of your food is home cooked?_____

Do you take diuretics?_____

How is the health of your father? _____
How is the health of your mother? _____

If deceased from what?_____

Your Serious illness / hospitalizations / injury/ surgery – please list all:

_____

*What is your chief health concern NOW?
_____

Do you have goals for your future?_____
_____

Do you find time for yourself-do you have any self care habits?

Please list them here

_____
_____

Any Other concerns? Please list_____
_____

What foods did you eat often as a child? List comfort foods.
breakfast- lunch -dinner -snacks -liquids.

_____

Answering all these questions helps me to get to know you better, in order to help you. Thank you for taking this first step. This information is all private and confidential information and will be kept in the strictest confidence.

Please Return to faces@vail.net

Thank you
Connie Rogers INHHC