

Elizabeth Deig, BA, CNC
Ph. 619/742-4117

Client Name: _____
Today's Date: _____

Please spend some time filling out the health profile below to assist me in more accurately getting to the root of your body's needs.

HEALTH PROFILE

Section I. Personal Information

Date of Birth: ____/____/____ Age: ____ Height: ____ Weight: ____

Gender: M/F Body Frame: (small, med, or large) _____ Blood Type: _____

Telephone: (home) _____ (work) _____ (other) _____

Address: _____

Email: _____

Occupation: _____

Home Environment: (spouse/partner, children, roommates, pets, etc.)

Ethnicity (optional): _____ Referred by: _____

Cholesterol _____ HDL: _____ LDL: _____ (date last checked: _____)

Section II. Current Health Concerns

Please check off any of the following that pertain to you (past or present – please mark present conditions with a P next to it):

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Difficulty losing weight | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Addiction (alcohol, drugs) | <input type="checkbox"/> Difficulty gaining weight | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Memory loss or confusion |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nails, poor growth |
| <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Bladder infections (Cystitis) | <input type="checkbox"/> Gout | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Bloating, gas, or indigestion | <input type="checkbox"/> Hair loss or poor hair growth | <input type="checkbox"/> Pregnant or nursing mother |
| <input type="checkbox"/> Blood sugar problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart disease or problems | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colds or flu (frequent) | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Severe mood swings |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Herpes simplex or type II | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Suicidal tendencies |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes I (insulin dependent) | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Diabetes II (adult onset) | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal problems | |

Elizabeth Deig, BA, CNC
Ph. 619/742-4117

Client Name: _____
Today's Date: _____

1. Please describe onset/occurrence of current or recent health issue(s).

2. Have you had these particular issues in the past? If so, how did you deal with them?
(i.e. doctor, self-care, etc.)

3. Have you made any recent changes to help deal with your current health issue(s)? If so, what were the changes?

4. Please list any other health practitioners you are currently seeing including specialty and phone number.

5. Please list all medications you are currently (or have recently) taken. Include birth control and over-the-counter medications as well:

6. Have you had any medical tests or lab assessments taken in the last 6 months? If so, please bring a copy and/or list below the results you discovered:

Section III: Eating Habits/Lifestyle

7. Are you a vegetarian or have an otherwise restricted diet protocol? If so, please specify:

8. Do you eat breakfast every day? Y/N

9. How many times a week do you dine out (on average):

Breakfast? _____

Lunch? _____

Dinner? _____

10. How many servings per week do you get of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Beef | <input type="checkbox"/> Fruit | <input type="checkbox"/> Luncheon Meats |
| <input type="checkbox"/> Poultry | <input type="checkbox"/> Vegetables | <input type="checkbox"/> Beer (12oz) |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Salad Dressing | <input type="checkbox"/> Wine (4oz) |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Frozen Entrees | <input type="checkbox"/> Liquor (1oz) |
| <input type="checkbox"/> Milk 2%, 1%, NF | <input type="checkbox"/> Snack Foods | <input type="checkbox"/> Coffee/Black Tea |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> Candy | <input type="checkbox"/> Decaf |
| <input type="checkbox"/> Butter/Margarine | <input type="checkbox"/> Juice | <input type="checkbox"/> Soda/Diet Soda (12oz) |
| <input type="checkbox"/> Added Salt | <input type="checkbox"/> Oil | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Nuts | <input type="checkbox"/> Potato/Rice/Pasta | <input type="checkbox"/> Sweets/Desserts |
| <input type="checkbox"/> Bread | <input type="checkbox"/> Canned Soup | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Beverage with a meal | <input type="checkbox"/> Eating to the point of discomfort | <input type="checkbox"/> Eating sitting with no distractions |
| <input type="checkbox"/> Eating in joy and comfort | <input type="checkbox"/> Remembering to chew well | |

11. Do you tend to over/under eat when you are: (place an O or U where they apply)

- | | | | | |
|--------------------------------------|--------------------------------------|--------------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Angry | <input type="checkbox"/> Happy | <input type="checkbox"/> Depressed | <input type="checkbox"/> Bored |
| <input type="checkbox"/> Socializing | <input type="checkbox"/> Need reward | <input type="checkbox"/> Watching TV | <input type="checkbox"/> Stressed | <input type="checkbox"/> Alone |

12. Do you use a microwave? If so, how many times per week? _____

13. Do you consume organic foods/beverages? If so, percentage in a week? _____

14. How much water do you drink in a day? _____

15. Please list all of the supplements you are presently taking:

Elizabeth Deig, BA, CNC
Ph. 619/742-4117

Client Name: _____
Today's Date: _____

16. Do you get any regular physical activity/exercise? Please describe:

17. Have you had any periods of malnutrition due to dieting or disordered eating (anorexia, bulimia, overeating, etc.)? If so, please explain:

18. Please list any environmental stressors you feel are significant toward your health (ex. pesticide spraying nearby, work with toxic chemicals, live near a factory)

19. Do you have any stress-releasing weekly activities? (yoga, meditation, music, art)

Section IV: Allergies/Sensitivities

20. Please list any known food allergies: _____

21. Please check any of the following foods that you **do not go a day without eating**:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bread products | <input type="checkbox"/> Soy | <input type="checkbox"/> Peanuts/peanut butter |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Corn/Corn products | <input type="checkbox"/> Tomato/Tomato Sauce |
| <input type="checkbox"/> Cow's milk | <input type="checkbox"/> Oranges/OJ | <input type="checkbox"/> Mushrooms |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> Beef | <input type="checkbox"/> Ice Cream |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Black Tea/Coffee | <input type="checkbox"/> Sugar |
| <input type="checkbox"/> Pasta | <input type="checkbox"/> Soda | <input type="checkbox"/> Cookies/Cake |
| <input type="checkbox"/> Beer | <input type="checkbox"/> Chips | <input type="checkbox"/> Mayonnaise/Margarine |
| <input type="checkbox"/> Nutrasweet/Splenda | | |

22. Circle check any of the following symptoms that you experience on a regular basis:

- | | | |
|---|---|---|
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Flatulence (gas) | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Dizziness when standing suddenly | <input type="checkbox"/> Tiredness/weakness with missed meals | <input type="checkbox"/> Hunger within 2 hours of eating a meal |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Craving for bread products |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Craving for sweets | <input type="checkbox"/> Easy weight gain |
| <input type="checkbox"/> Impatience | <input type="checkbox"/> Dry skin/hair | <input type="checkbox"/> Trouble losing weight |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Poor concentration/memory | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Increased thirst |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Acid reflux |

23. Do you have any known reactions to food dyes or preservatives? If so, which ones:

Elizabeth Deig, BA, CNC
Ph. 619/742-4117

Client Name: _____
Today's Date: _____

24. Do you have asthma? _____
25. Do you ever get hay fever? _____ What time of year? _____
26. Are you allergic to any animals (cats, dogs, etc.)? _____
27. Are you regularly in a chlorinated swimming pool or hot tub? _____
28. Do you have any reactions to any other inhalants or anything else in your environment? _____
29. How many times in a year do you get a cold or a flu? _____
30. How many times in a year do you take antibiotics? _____

Section V: Sleep and Digestion

SLEEP:

31. What time do you go to bed? _____ wake up? _____
32. Do you have trouble falling asleep? _____ trouble staying asleep? _____
33. How many times do you wake up/get up during the night? _____

DIGESTION:

34. Are you constipated? _____ If so, is it frequent or occasional? _____
35. Do you have a bowel movement at least once per day? _____
36. If not, how often? _____ If more than once, how many times? _____
37. Do you experience diarrhea? If so, is it frequent or occasional? _____

Section VI: Family History

38. Please list any significant medical conditions or diseases in your family (ex. diabetes, cancer, heart disease, asthma, allergies) along with family member's relationship to you. (ex. Paternal grandmother, mother's sister, etc.)

Elizabeth Deig, BA, CNC
Ph. 619/742-4117

Client Name: _____
Today's Date: _____

39. What were your family's eating habits growing up? (ex. Pleasant or unpleasant eating environment; pressure to eat foods you did not like; no formal meals; home-cooked meals) Please describe as best you can remember:

Section VII: Women's Health

40. Age of first period: _____
41. When was your most recent period? _____
42. Any patterns of irregular menses? _____
43. Have you ever been pregnant? _____
44. Have you ever taken a birth control pill? _____ For how long? _____
45. Have you borne any children? If so, how many? Any major complications?

46. Have you had a hysterectomy? _____ At what age? _____
What organs were surgically removed? _____

47. Have you experienced perimenopause or menopause? _____ At what age? _____

If so, check any of the following symptoms that you have had monthly:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Facial Hair |
| <input type="checkbox"/> Vaginal itching/burning | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Joint pain |

48. Are you currently undergoing hormone replacement therapy?

Please describe: _____