### Health Evaluation Profile (Please complete all 3 pages)

**Section I. Personal Information**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I thank the person who referred you? YES NO

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip\_\_\_\_\_\_

Phone (mobile)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (day)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (eve)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_ Body Frame: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Target weight if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise/Recreation - activity, time, intensity (High, Med, Low) per week

### Section II. Health Concerns (use reverse side or additional pages as needed)

1. List top 5 health concerns in order of importance.
2. Describe onset and history of primary health concerns**.**
3. How have you dealt with in the past/are you presently dealing with these concerns (doctors, self-care)?
4. List any medicines you are taking for these or other health concerns. (Please put supplements on supplement dosing chart)
5. Describe family (parents, children, siblings) health history (deceased at what age, diabetes, cancer, thyroid, allergies, digestive concerns, heart disease, etc.)?
6. Describe your sleep: (fall asleep, stay asleep, wake up during night, insomnia, wake up early, sleep short hours, etc.)
7. How would you rate your level of stress in the following areas: (on a scale of 1-10. 1 being low stress)
	1. Work \_\_\_\_\_\_\_\_\_\_
	2. Family \_\_\_\_\_\_\_\_\_\_
	3. Relationships \_\_\_\_\_\_\_\_\_\_
	4. Environmental (allergies or toxic exposures) \_\_\_\_\_\_\_\_\_\_
	5. Financial
	6. Other (describe) \_\_\_\_\_\_\_\_\_\_
8. How has your diet changed in relation to your health concerns (special diets you’ve tried, etc. and results)
9. Describe the foods you eat (comfort foods) when you are:

 a. Hungry b. Lonely c. Depressed

* + 1. Angry e. Tired f. Celebrating
1. Please describe any spiritual practices.

11. Please describe your support system.

12. Is there anything else I should know?