HEALTH HISTORY

SPEAR Training & Consulting, LLC

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age ____ Height ____ Sex ____ Number of Children ____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Operation, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Medical History

- ❑ Arthritis
- ❑ Allergies/hayfever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ BPH
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ STD

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ PMS
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ STD

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _____

Length of cycle ____ days

Interval of time between cycles ____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (parents and siblings)

- ❑ Arthritis, rheumatoid
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

- ❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (e.g., Ensure)

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

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