Date of Session:_____
Name:_____

CONFIDENTIAL HEALTH HISTORY and PERSONAL VISION - INFORMATION
This information is not shared with anyone. Fill out as much or as little of this form as you would like. There is no judgement.

~Age:

~What is the specific health concern(s)? Include severity & frequency. Challenges? Frustrations?

~ What is the length of time with this concern?

~How have you navigated with these concerns? Doctor? Selfcare?

Was there success with these approaches?

~Are you working with other practitioners?

~Current prescriptions, supplements and herbs.

~VISION for life for the Short Term and Long Term?

~What do you do for fun? What brings you joy?

~What does the family do for fun? (If applicable)

~Favorite things? Places?

~At what point in your life did you feel the best?

~How busy is life? Is there downtime? What is home life like?

~Meals (Typical options)

Breakfast:

Lunch:

Dinner:

Snack:

Beverage:

~On average, how many (or what percentage of) meals are home-cooked per week?

~Favorite/Preferred Foods (Type of food, textures, smells, etc)

~Foods Disliked. (Types of food, textures, smells, etc)

~Sleep.

Amount of sleep?

Quality of sleep?

Nightmares?

Night wakings? If so, what time? OR different times?

Naps? If so, how often?

~Physical discomfort? From food or other sources. Specify if known.

Food Reactions?

Food Allergies/Sensitivities?

Bellyaches?

Headaches?

Earaches?

Itchy?

Pain, stiffness, swelling?

Skin issues?

Seasonal allergies?

Environmental allergies?

Other?

~Bowel Movement Frequency

- ○ 1-3 times per day
- ○ more than 3 times per day
- ○ not regularly every day

Other Bowel Movement Comments:

~How is your period? (Women)

Regular?_____ How many days is your flow?_____ How frequent?_____

Painful? Symptomatic?

Menopause?_____ If so, at what age?

Birth Control History:_____

~Emotional reactions? Specific triggers?

~Have you experienced trauma? And/Or Do you experience PTSD?

~Is there anything you are internalizing that needs to be released? Emotions like anger or grief, thoughts, words, etc.

~Any surgeries including dental procedures? Do you have amalgams?

~Is there a history of pharmaceutical use/exposure? (ie Vaccines, antibiotics, prescriptions, OTC drugs, etc)? Have you received the 'Covid-19 Vaccine'? If so, which one, how many doses, and when? The timeline may be relevant to health history.

~Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

~Is there someone in your life who can be your support/cheerleader in your health journey?

~Additional Questions? Comments? Other useful information.