Fit to You, LLC
Health History Form

Please write or print clearly.

General Information

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone—Work: _____ Home: _____ Cell: _____

Email address: _____ Date of Birth: _____ Place of birth: _____

Age: _____ Height: _____ Current weight: _____ Weight six months ago: _____

Weight one year ago: _____ Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____ Children: _____

Occupation: _____ Hours worked per week: _____

Health History

Please list your main health concerns in the order of importance: _____

_____

Do these health concerns interfere with (check all that apply): □ work □ sleep □ daily routine □ other ___

Are your symptoms getting progressively worse? □ Yes □ No

Is your condition: □ Constant □ Intermittent

Has there been any medical diagnosis of your complaint? □ Yes □ No If yes, list the doctor's name and the diagnosis. _____

How have you tried to take care of this problem in the past? Circle all that apply.

Medications ● Emergency room ● Surgery ● Routine medical ● Exercise ● Supplements

Chiropractic care ● Naturopathic care ● Acupuncture ● Nutrition ● Personal trainer ● Other: _____

How did the previous method(s) work for you? _____

Why do think this is the case? _____

Where do you picture yourself being in the next 1 to 3 years if this problem is not taken care of? Please be specific. _____

What would be different or better without this problem? Please be specific. _____

_____

What do you desire most to get from working with us? _____

What is that worth to you? _____

Please list any medications you currently take and for what conditions:

_____

_____

Please list any natural supplements you currently take and for what conditions:

_____

_____

Please list any other concerns and/or goals: _____

_____

Why do you feel your health is the way it is? _____

_____

At what point in your life did you feel the best? What were you doing then? _____

_____

Please list any serious illnesses/hospitalizations/injuries? _____

_____

How is the health of your mother? _____

How is the health of your father? _____

Any other family history we should know about? _____

What is your ancestry? _____ What blood type are you? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? If yes, where? _____

Emotional Health/Stress

How stressful is your life on a scale of 1 to 10, 10 being the most stressful? _____

What do you feel is the major cause of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute)? _____
How do you cope with stress? _____

How often do you feel you have something that must be done? _____

How often do you feel overwhelmed? _____

How often do you have difficulty falling into deep, restful sleep? _____

Do you ever feel paranoid? _____

How often do you feel sad or down for no reason? _____

Have you lost your enthusiasm for your favorite activities? _____

Have you ever had self-destructive thoughts? _____

How often do you have an inability to handle stress? _____

How often do you prefer to isolate yourself from others? _____

Do you find it difficult to finish tasks? _____

Do you feel like your libido has been decreased? _____

Do you ever feel anxious or panicked for no reason? _____

How difficult is it to turn your mind off when you want to relax? _____

Have you ever been diagnosed with any of the following?

□ Depression □ Anxiety □ Bipolar disorder □ ADD/ADHD □ OCD □ Schizophrenia □ Other: _____

Are you taking an anti-depressant or other psychiatric medicine? □ Yes □ No

If yes, which medication(s) are you taking? _____

For women only

Have you ever been pregnant? □ Yes □ No

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Birth weight of smallest baby _____

Did you develop toxemia (high blood pressure)? □ Yes □ No

Have you had other problems with pregnancy? □ Yes □ No If yes, please describe.

_____

Date of last Pap Smear _____ Normal/Abnormal

Date of last Mammogram _____ Normal/Abnormal

Age of first period _____ Are your periods regular? _____ How many days is your flow? _____

What is your cycle length? _____ Painful or symptomatic? Please explain. _____

_____

Do you currently use contraception? □ Yes □ No Current birth controlled used: _____

What birth control have you used in the past? _____

Do you experience yeast infections or urinary tract infections? Please explain.

_____

Reached or approaching menopause? Please explain: _____

If yes, age of last period. _____

If you are menopausal are you having symptoms? Please explain? _____

_____

Are you on hormone replacement therapy? □ Yes □ No If yes, which type? _____

How long have you been on hormone replacement therapy (if applicable)? _____

Do you have any of the following currently or in the past (circle all that apply)?

Hot flashes ● PMS ● Cramps ● Tender breasts ● Infertility ● PCOS ● Endometriosis ● Uterine polyps

Uterine fibroids ● Breast cancer ● Facial hair growth ● Hypothyroidism ● Migraines ● Hysterectomy

Digestive Symptoms/Food Patterns

Do you have any of the following currently or in the past (circle all that apply)?

Constipation ● Diarrhea ● IBS ● Gas ● Bloating ● Heart burn ● Crohn's Disease ● Ulcerative colitis

Diverticulosis ● Celiac Disease/gluten sensitivity ● Food allergies ● Food sensitivities

Leaky gut syndrome ●Lactose intolerance ● Gallstones

Are you on a special diet (Indicate what type of diet you are on.)? □ Yes □ No

□ Ovo-lacto vegetarian □ Vegetarian □ Vegan □ Dairy restricted □ Gluten Free □ Diabetic

□ Other (Please describe) _____

Is there anything else about your diet that we should know? _____

Do you have any allergies or sensitivities? Please explain: _____

_____

Do you have symptoms <u>immediately</u> after eating (belching, bloating, sneezing, hives, etc.)? □ Yes □ No

If yes, are these symptoms associated with any particular food or supplement(s)? □ Yes □ No

Please name the food or supplement and symptom(s). Example: Milk—gas and diarrhea.

_____

_____

Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? □ Yes □ No

Do you feel much **worse** when you eat a lot of (Circle all that apply.):

High fat foods ● High protein foods ● High carbohydrate foods (breads, pastas, potatoes)

Refined sugar (junk food) ●Fried foods ● 1 or 2 alcoholic drinks ● Other _____

Do you feel much **better** when you eat a lot of (Circle all that apply.):

High fat foods ● High protein foods ● High carbohydrate foods (breads, pastas, potatoes)

Refined sugar (junk food) ● Fried foods ● 1 or 2 alcoholic drinks ● Other _____

Does skipping a meal greatly affect your symptoms? □ Yes □ No

Have you ever had a food that you craved or really “binged” on over a period of time? □ Yes □ No

If yes, what food(s)? (Food craving may be an indicator that you may be allergic to that food.)

_____

_____

Do you ever feel that you have lost control of what or how much you are eating? _____

If so, how often does this happen? _____

Do you eat when you are stressed? _____ Tired?_____ Bored? _____ Upset? _____

Are there certain foods that you strongly dislike? □ Yes □ No

If yes, which foods? _____

If you could change one thing about your diet to improve your health, what would it be?

_____

_____

Describe the frequency of your bowel movements (circle the answer that applies).

More than 3X/day ● 1 to 3X/day ● 4 to 6X/week ● 2 to 3X/week ● 1 or fewer X/week

Describe the consistency of your bowel movements (circle the answer(s) that applies).

Soft and well-formed ● Often float ● Difficult to pass ● Diarrhea ● Thin, long or narrow ● Small and hard

Loose but not watery ● Alternating between hard and loose/watery

Describe the color of your bowel movements (circle the answer that applies).

Medium brown consistently ● Very dark or black ● Greenish color ● Blood is visible ● Varies a lot

Dark brown consistently ● Yellow, light brown ● Greasy, shiny appearance

Do you have intestinal gas? □ Yes □ No If yes, please describe by circling the appropriate answers.

Daily ● Occasionally ● Excessive ● Present with pain ● Foul smelling ● Little odor

Do you eat breakfast? □ Yes □ No If so, what do you typically eat for breakfast?

_____

What do you typically eat for lunch? _____

What do you typically eat for dinner? _____

Do you snack? □ Yes □ No If yes, what do you usually snack on? _____

What do you typically drink during the day? _____

The healthiest three foods I eat during the week are _____ _____ _____.

The worst three foods I eat during the week are _____ _____ _____.

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

What percentage of your food is home cooked? _____ Do you cook? _____

Where do you get the rest from? _____

Exercise/Recreation

Do you exercise? □ Yes □ No If yes, please describe your exercise frequency.

Daily ● 5 to 6X per week ● 3 to 5X/week ● 1 to 3X per week

What type(s) of exercise do you participate in (circle all that apply)?

Cardiovascular (walk, bike, run) ● Strength training ● Pilates ● Yoga ● Flexibility ● Group exercise

Personal training ● Martial arts ● Boxing/kickboxing ● Basketball ● Baseball ● Tennis

Other: _____

When you exercise, how long is each session? 15 minutes or less ● 16 to30 minutes ● 31 to 45 minutes

46 to 60 minutes ● 61 to 90 minutes ● more than 90 minutes

Do you have any hobbies or other leisure activities? _____

Lifestyle

Have you ever used alcohol? □ Yes □ No If yes, how often do you now drink alcohol (Please circle)?

No longer drinking alcohol ● Average 1-3 drinks per week ● Average 4-6 drinks per week

Average 7-10 drinks per week ● Average >10 drinks per week

Have you ever had a problem with alcohol? □ Yes □ No

If yes, please indicate time period (month/year): From _____ to _____.

Have you ever used recreational drugs? □ Yes □ No

Have you ever used tobacco ? □ Yes □ No

If yes, number of years as a nicotine user: _____. Amount per day: _____. Year quit: _____.

If yes, what type(s) of nicotine have you used (circle all that apply)?

Cigarette ● Smokeless ● Cigar ● Pipe ● Patch/gum

Have you ever been exposed to second hand smoke regularly? □ Yes □ No

How many caffeinated beverages do you consume per day? _____

Do you have mercury amalgam fillings? □ Yes □ No

Do you have any artificial joints or implants? □ Yes □ No If yes, where? _____

Do you feel worse at certain times of the year? If yes, when? _____

Have you, to your knowledge, been exposed to toxic metals in your job or at home? □ Yes □ No

If yes, which one(s)? Lead ● Arsenic ● Aluminum ● Cadmium ● Mercury

Do odors affect you? □ Yes □ No If yes, which ones? _____

Readiness to Change

Will family and/or fiends be supportive of your desire to make food and/or lifestyle changes? _____

Are you willing to change what you believe about health and the body to improve your health? _____

Are there any patterns in childhood or adulthood that has contributed to your health problems?

_____

_____

Is there anything else you would like to share?

_____

_____

FOR OFFICE USE ONLY:

Follow up assessments and forms required:

□ Metabolic assessment □ Neurotransmitter assessment □ PAR-Q □ Doctor's release for exercise □ Training waiver and release

□ Seven day food log □ Postural assessment □ Cardiovascular assessment □ Range of motion assessment □ Body composition

Additional testing required: _____

Recommendations: □ Nutrition counseling □ Personal Training □ Small Group Training □ Referral: _____

Time period recommended: _____

Follow up appointment: _____

Comments/Notes: