Health History

OFFICE USE ONLY

Name: ______________________ Date: __________
Address: ______________________
City: ______________________ State: ______ Zip: __________

Phone: ______________________ Email: ______________________
How do you prefer to be contacted? ☐ Phone ☐ Text ☐ Email Occupation: ______________

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Date of Birth: __________ Age: ____ Gender: ☐ Male ☐ Female Height (ft): ______ Weight (lbs): ______

How did you hear about the SHAPE Program? ______________________
BLOOD WORK: If you have recent blood work (within the last 6 months), please include a copy with this form.

QUESTIONNAIRE

What are your three most important current health concerns?
1. ______________________
2. ______________________
3. ______________________

List any medical problems currently being managed by a physician: ______________________

List any surgeries with dates: ______________________

List any allergies to food, drugs or other known allergies: ______________________

List all supplements you are taking on a routine (daily - monthly) basis, include dose: ______________________

List all prescription and over-the-counter drugs you are taking on a routine (daily - monthly) basis: ______________________

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Have you tried the SHAPE Program previously? If so, when? ______________________________

What was/wasn't successful about the SHAPE Program? ______________________________

____

What other programs have you tried? ______________________________

____

What was/wasn't successful about the other program(s)? ______________________________

____

What are the main stresses in your life? ______________________________

____

Have you experienced any life-changing stressful events? ______________________________

____

What do you do to de-stress?______________________________

____

What are some of your hobbies? ______________________________

____

Why do you want to do the SHAPE Program? ______________________________

____

What is your activity level on a scale from 1-10? (10 being very active) ______________________________

What is your average energy level on a scale of 1-10? (10 being the optimal energy level you think you *should* have) ______

Do you feel you get adequate sleep?	☐ Yes	☐ No	______________
Do you wake rested?	☐ Yes	☐ No	______________
Do you wake during the night? At what time?	☐ Yes	☐ No	______________
Do you sleep next to any electronic devices?	☐ Yes	☐ No	______________
Do you exercise?	☐ Yes	☐ No	______________
Do you follow any particular diet?	☐ Yes	☐ No	______________
Do you consume caffeine daily?	☐ Yes	☐ No	______________
Do you use tobacco?	☐ Yes	☐ No	______________
Do you consume alcohol?	☐ Yes	☐ No	______________
Do you feel you've ever had a problem with overuse of drugs or alcohol?	☐ Yes	☐ No	______________
Do you have a good support system?	☐ Yes	☐ No	______________
Do you have a spiritual practice?	☐ Yes	☐ No	______________

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SYMPTOMS/CONDITIONS

Check the boxes of symptoms/conditions that you have experienced over the last 6 months.

Wood:

- ☐ Back pain
- ☐ Brittle nails
- ☐ Bursitis/Tendonitis
- ☐ Headaches/Migraines
- ☐ Gallbladder problems
- ☐ Gout
- ☐ Irritable/Angry
- ☐ Hepatitis/Liver disease
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Muscle weakness
- ☐ Paralysis

Fire:

- ☐ Anxiety
- ☐ Bleed or bruise easily
- ☐ Chest pain/pressure
- ☐ Depression
- ☐ Environmental sensitivities
- ☐ Fainting/Dizziness
- ☐ Food intolerances
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Hot/Cold intolerance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Insomnia
- ☐ Palpitations
- ☐ Memory loss
- ☐ Nose bleeds
- ☐ Numbness/Tingling
- ☐ Seizures/Epilepsy
- ☐ Tremors
- ☐ Varicose veins

Earth:

- ☐ Acid reflux
- ☐ Abdominal Pain
- ☐ Cold/Canker sores
- ☐ Diabetes
- ☐ Excessive thirst/hunger
- ☐ Gas/Bloating
- ☐ Hemorrhoids
- ☐ Hypoglycemia
- ☐ Indigestion
- ☐ Insulin resistance
- ☐ Irritable when hungry
- ☐ Nausea/Vomiting
- ☐ Tired after eating
- ☐ Ulcers
- ☐ Worrisome

Metal:

- ☐ Acne
- ☐ Asthma
- ☐ Constipation
- ☐ Cough
- ☐ Despair/Apathy
- ☐ Diarrhea
- ☐ Eczema
- ☐ Emphysema
- ☐ Gingivitis
- ☐ Hay fever
- ☐ Hives
- ☐ Psoriasis
- ☐ Rashes/Itchiness
- ☐ Respiratory infections
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin tags
- ☐ Wheezing/Hoarseness

Water:

- ☐ Arthritis
- ☐ Chronic urinary tract infections
- ☐ Dentures
- ☐ Edema
- ☐ Excess libido
- ☐ Fearful
- ☐ Frequent ear infections
- ☐ Hair loss
- ☐ Hearing loss
- ☐ Incontinence
- ☐ Infertility
- ☐ Joint pain
- ☐ Kidney stones
- ☐ Low blood pressure
- ☐ Low libido
- ☐ PMS
- ☐ Prostate issues
- ☐ Ringing in ears

Other:

- ☐ Autoimmune disease
- ☐ Bleeding gums
- ☐ Employment difficulties
- ☐ Erectile dysfunction
- ☐ Hernia
- ☐ History of abuse
- ☐ History of antibiotic use
- ☐ History of vaccine reactions
- ☐ Relationship problems
- ☐ Restless legs
- ☐ Schizophrenia
- ☐ Serious head injury
- ☐ Children (list age) ______________________________

Bowel movements/day __________

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Women Only:

- ☐ Breast masses
- ☐ Hysterectomy
- ☐ Irregular periods
- ☐ Lack of periods
- ☐ Menopause (age) ________
- ☐ Painful/Heavy periods
- ☐ Spotting
- ☐ Vaginal discharge
- ☐ Yeast infections

☐ Pregnancies #________________ ☐ C-section #____________ ☐ Miscarriage #/date ____________

Are you/Do you plan to become pregnant? ☐ Yes ☐ No ____

Are you breastfeeding? ☐ Yes ☐ No ____

Are you taking birth control? What kind? ☐ Yes ☐ No ____

Are you on hormone replacement therapy? ☐ Yes ☐ No ____

INFORMED CONSENT

I, ________________________________, understand that the SHAPE Program is a lifestyle modification, health restoration program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary healthcare experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dose adjustments. I agree to notify my prescribing physician that I am working with ________________________________ and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutrition protocol will be recommended based on my unique health history, urinalysis and symptoms.

NOTES (Practitioner only)

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