Men Health History for My Pure Intentions

http://mypureintentions.com

Please fill this Confidential Health History form out and send it back to me 2-3 days PRIOR to your consultation. This will offer you the best value during our interview.

Name: ____ Date: ______________ DOB: _______
Address: ______________________________________ Home# _____________ Cell # _____________
Email: ____
Occupation: ______________________Hours/week _____ Employer: _____________________________
Name of partner/spouse: ________________________________ Marital Status: ___________________
List the ages and names of your children and step children

____

____

Have you seen a Health Coach before? (Y/N) When? ____
How was the experience? ____
What is your primary health concern or main reason for coming today?

____

____

____

When did your symptoms or health concern start?

____

Describe your symptoms: ____

____

What seems to make it better? ____
What makes it worse? ____
Are there related symptoms? ____

List in order of importance other health problems/concerns that are troubling you:
*What do you feel/think is causing your health concern(s)?
1. _________________________________ since: ____________causes*: _________________________
2. _________________________________ since: ____________causes*: _________________________
3. _________________________________ since: ____________causes*: __________ _______________
4. _________________________________ since: ____________causes*: _______________________ __

How would you describe your general state of health? Excellent good fair poor
How would you describe your parents' state of health? Excellent good fair poor (explain)

____

____

Are you currently under the care of any Health care practitioners? *(check all that apply)*
______Chiropractor ______Acupuncturist ______Massage therapist
______Physiatrist ______Physical Therapist ______Homeopath
______Medical Doctor ______Reiki ______Reflexology
______Allergist ______Oncologist ______Cardiologist
______Rheumatologist ______Gastroenterologist ______Dermatologist
______ Counselor/Psychotherapist
Other: ____

When do you last remember feeling really great? ____

How long do you think it'll take to improve your health concerns? _________________
When you're thinking of how soon you want results, consider how long you've had the condition.

Date of last physical: _________________________
Name of medical doctor: _______________________________ Tel: ________________
Have you had any accidents, conditions, illnesses, injuries, surgeries or hospitalizations which affected your health in such a manner that you've never been totally well since? Y/N
If so, please list the type of condition and the approximate date it occurred:

____

____

Quite often my clients need lab work for data we will use for the healing journey. Are you willing to have more lab work done?   Yes _____ No ______
Occasionally insurance companies decline claims for non-traditional testing.
If this were the case with you; are you willing to pay out of pocket? Yes _____ No _____

Have you used or are you currently using any of the following? Indicate (Y/N), the name, frequency and length of time you have taken these:

- Laxatives - Antidiarrheal ____
- Antacid - bloating ____
- Antibiotics: ____
- Probiotics ____
- Corticosteroid creams or pills: ____
- Pain killers (aspirin, Tylenol, ibuprofen, narcotics, etc.): ______________________________________
- Thyroid medication: ____
- Iron, folate, B12 ____
- Sleeping aides: ____
- Recreational drugs: ____
- Nasal sprays/allergy pills: ____

Have you ever had allergy testing done? ____________ Was it blood, stool or skin patch testing? ___________
Where there any allergies?

____

____

Please list all medication(s) not mentioned above, the amount you're taking and the condition(s) it's for:

____

____

____

List vitamins/minerals/supplements/herbs/remedies you're taking, amount(s), and reason:

____

____

____

What is your height ___________ Weight _________

Weight 6 months ago __________ Weight 1 year ago _______________ Goal weight _____________
Any weight concerns? (now/past) (gained/lost)

____

What have you tried to gain/lose weight?

____

How many meals do you have/day? _________ Do you skip meals? ____________________________________
Do you have any complaints with your digestion? ____
How often do you have a bowel movement? ____
Are your bowels ___ hard___ loose ___ combination___ neither ("regular") ___________________________

How is your sleep? __________________ Difficulty falling asleep?________ Waking in the night? _________
Bed time: _______ Rising time: _______ Do you feel rested when you wake up? ______________
How many hours of sleep do you get each night? _____
Are your sleep habits regular? ___________________________
How often do you wake in the night to urinate? ____________________________________
What else wakes you at night? ____
Any dreams (recurrent/not) or nightmares? ______________________________________
What's your energy level (1-10; 10=high)? _______________________________________
Do you meditate or use relaxation techniques? ___________________ How often? _______ Results? _______
Have you tried Yoga or Tai Chi in the past? _________________ How often? __________ Results? _________
Do you enjoy your work? ____________________ Do you take vacations? ____________
Do you follow any religious or spiritual/peaceful practice? _______ Please specify:

____

____

What do you enjoy most in your life? ______________________________Do you have time for this? _______
What do you worry most about in life? ____
What is your stress level (1-10; 10==high)? _________What are the things that you find stressful in your life?

____

Is your Mom alive Y N How old is she now or was she when she passed? ______ What medical struggles did she have? ____
Is your Dad alive Y N How old is he now or was she when she passed? ______ What medical struggles did he have? ____
Who lives with you? ______________________________ Are they supportive of you working with a health coach? ____
How many siblings do you have? _____ What is their health like?

____

____

Are there any other family health conditions you worry may affect you? (who had this?)

____

List types, ages and names of pets

____

What role does sports and exercise play in your life? _____________ What is your typical sports or exercise each week? ____

How many glasses of each do you have daily? (0-10)

Water ______ Coffee ______ Tea ______ Energy drink _____ Milk ______ Sports drink _____ Juice ______
Wine _____ Beer ______ Mixed drink ______

What percentage of your food is cooked at home? ______________%
Where do you get the rest from? ____
What is your typical
Breakfast ____
Lunch ____
Dinner ____
How does this vary from how you ate as a child? ____

Do you crave sugar, coffee, cigarettes, or have any major addictions? When?
____

What relationships in your life are satisfying? ____
____
Do you have any relationships that are challenging or difficult?
____
____
How would you describe your relationship(s) with your partner/ children/ parent(s)/employer?
____
____

Has there been any traumatic experience or major loss in your life? ___________________________________
____ Age at time of trauma: _____________
Where have you last traveled outside of Canada/US? ____
____When? ____________________________

Have you been exposed to toxic chemicals (from home/where you live/work: paints, industrial cleaners, pesticides, orchards, golf courses, water)?
____
____
____
Have you ever been tested for toxins or heavy metals? ____
Have you ever lived in a home with smokers? If so, when? ____
Have you ever had silver fillings put in your teeth? If so, when? _____________________________________
Have you ever had silver fillings replaced? If so, when? ____
Have you ever had reactions to any vaccinations, medications, or supplements? If yes, what and when?
____
____
Have you suffered with recurrent yeast or skin infections? ________ what did you treat those with and when?
____
Are there any incidents of physical, emotional or sexual abuse in your past?
____
Have you experienced trouble with intimacy? ______ please explain ___________________________________
Is there anything else you would like to share?
____

Thank you for your time. This information is valuable for Pure Intentions!