Pickled Beet
HEALTHY • WHOLE • NUTRITION

Health Information Form

Date (MM/DD/YYYY): _____

Name:_____ D.O.B. (MM/DD/YYYY): _____ Sex: ❍ M ❍ F

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

Phone: PRIMARY_____ SECONDARY_____

Email: _____

Occupation: _____

Height:_____ Weight:_____ Committed Relationship? ❑ Yes ❑ No Children? ❑ Yes ❑ No If Yes, #_____

Referred by: _____

Current Health Goals:

1. _____

2. _____

3. _____

List any medical conditions I should know about:_____

_____

List any medications, herbs and/or supplements you are currently taking:_____

_____

Personal and Family History

Father: ❑ Alive ❑ Deceased. Present health or cause of death: _____

Mother: ❑ Alive ❑ Deceased. Present health or cause of death: _____

Siblings: # Alive: _____ # Deceased: _____ Present health or cause of death: _____

_____

Children: # Alive: _____ # Deceased: _____ Present health or cause of death: _____

_____

Check any illnesses which have occurred in any of your blood relatives:

❑ Diabetes ❑ Cancer ❑ Bleeding tendency ❑ Kidney disease ❑ Tuberculosis ❑ Obesity ❑ Heart disease
❑ High blood pressure ❑ Nerve disorder ❑ Allergy ❑ Alcoholism ❑ Mental illness ❑ Stroke ❑ HIV/AIDs

Other: _____

Check any illnesses or conditions you have or had in the past:

- ❑ Allergies
- ❑ Asthma
- ❑ Autoimmune disorders
- ❑ Bladder infections
- ❑ Bleeding tendencies
- ❑ Cancer
- ❑ Candidiasis
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Gallbladder trouble
- ❑ Glaucoma
- ❑ Heart trouble
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High fevers
- ❑ HIV / AIDs
- ❑ Jaundice
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Lots of Antibiotic use
- ❑ Measles
- ❑ Meningitis
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Nervous disorder
- ❑ Parasites
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic fever
- ❑ STD
- ❑ Thyroid condition
- ❑ Tuberculosis
- ❑ Vein trouble
- ❑ Other:_____

_____

List any surgeries and date: _____

_____

List any serious illnesses / accidents / trauma history and date: _____

_____

List any allergies or sensitivities: _____

Currently pregnant? ❑ No ❑ Yes If Yes, how many months? _____

Last Physical Exam (MM/DD/YYYY):_____ Last Pap Smear (MM/DD/YYYY):_____

Last Mammography (MM/DD/YYYY):_____ Last Prostate Test (MM/DD/YYYY):_____

Last Blood test (MM/DD/YYYY):_____ (what was tested):_____

_____

Test results: _____

_____

Check any/all that apply currently or within the past six months:

General
- ❑ fatigue
- ❑ sleep problems
- ❑ swollen glands
- ❑ hot or cold intolerance
- ❑ frequent headaches
- ❑ weight loss / gain
- ❑ fever or chills
- ❑ allergies
- ❑ nervousness
- ❑ depressed
- ❑ irritable

Emotional
- ❑ anxiety or worry
- ❑ frequent crying
- ❑ anger
- ❑ chronic tension
- ❑ mood swings
- ❑ fear
- ❑ restlessness
- ❑ confusion
- ❑ depression
- ❑ suicidal

Head
- ❑ headache *(please note which area)*:
  - ❑ entire head
  - ❑ back of head
  - ❑ forehead
  - ❑ temples
  - ❑ migraine

Head (cont.)
- ❑ head feels heavy
- ❑ loss of memory
- ❑ light-headedness
- ❑ fainting
- ❑ loss of smell
- ❑ loss of taste
- ❑ loss of balance
- ❑ dizziness
- ❑ loss of hearing
- ❑ pain radiating into face
- ❑ buzzing in ears
- ❑ sensitivity (note which):
  - ❑ light
  - ❑ sound
  - ❑ smell

Neck
- ❑ neck pain
- ❑ neck pain w/ movement
- ❑ pinched nerve in neck
- ❑ neck feels out of place
- ❑ stiff neck
- ❑ muscle spasms in neck
- ❑ popping sounds in neck
- ❑ arthritis in neck
- ❑ pain radiates
- ❑ limited range of motion

Shoulders
- ❑ pain in shoulder joints
- ❑ pain across shoulders
- ❑ bursitis: ☐R ☐L
- ❑ arthritis: ☐R ☐L
- ❑ can't raise arm
- ❑ tension in shoulders
- ❑ pinched nerve in shoulder
- ❑ muscle spasms in shoulders

Ear/Nose/Throat
- ❑ earache
- ❑ ear discharge
- ❑ ringing in ears
- ❑ hearing loss
- ❑ loss of smell
- ❑ mouth breather
- ❑ snore when sleeping
- ❑ nosebleeds
- ❑ hoarseness
- ❑ problems swallowing
- ❑ swollen glands or throat
- ❑ jaw tight or sore
- ❑ dental problems
- ❑ glasses/contacts

Nervous System
- ❑ dizziness
- ❑ blurred vision
- ❑ fainting
- ❑ paralysis

Nervous System (cont.)
- ❑ tremors
- ❑ numbness/tingling
- ❑ convulsions
- ❑ imbalance
- ❑ memory loss
- ❑ muscle weakness

Back Pain
- ❑ arthritis
- ❑ low back pain
- ❑ mid back pain
- ❑ pinched nerve
- ❑ muscle spasms
- ❑ pain stabbing
- ❑ pain between shoulder blades
- ❑ pain radiates down leg
- ❑ worse when:
  - ❑ working
  - ❑ lifting
  - ❑ twisting
  - ❑ stooping
  - ❑ standing
  - ❑ sitting
  - ❑ lying
  - ❑ bending
  - ❑ coughing
- ❑ slipped disk
- ❑ back feels out of place
- ❑ rib feels out of place

Arms & Hands
- ❑ pain in:
  - ❑ upper arm: ☐R ☐L
  - ❑ forearm: ☐R ☐L
  - ❑ wrist: ☐R ☐L
  - ❑ hands: ☐R ☐L
  - ❑ fingers: ☐R ☐L
- ❑ pins & needles:
  - ❑ in arms
  - ❑ in hands
- ❑ arms / hands / fingers go to sleep
- ❑ hands cold
- ❑ swollen joints in fingers
- ❑ arthritis in fingers
- ❑ loss of grip strength

Hips, Legs & Feet
- ❑ pain in buttock: ☐R ☐L
- ❑ pain in hip joint: ☐R ☐L
- ❑ pain down leg: ☐R ☐L
- ❑ leg cramps
- ❑ pins & needles in legs: ☐R ☐L
- ❑ numbness in legs / feet: ☐R ☐L
- ❑ feet feel cold
- ❑ cramps in feet: ☐R ☐L
- ❑ legs restless or jumpy
- ❑ pain in knee: ☐R ☐L

Hips, Legs & Feet (cont.)
- ❑ swollen ankles / feet: ☐R ☐L
- ❑ pain in feet: ☐R ☐L

Musculoskeletal
- ❑ joint inflammation
- ❑ joint pain
- ❑ muscle spasms
- ❑ neck pain
- ❑ shoulder pain
- ❑ elbow pain
- ❑ hand sensations
- ❑ loss of grip
- ❑ mid-back pain
- ❑ rib pain
- ❑ low back problems
- ❑ hip pain
- ❑ foot problems
- ❑ leg cramps

Musculoskeletal (cont.)
- ❑ knee pain
- ❑ ankle weakness
- ❑ tingling or numbness
- ❑ stiffness
- ❑ pain around ribs

Gastrointestinal
- ❑ change in appetite
- ❑ thirst
- ❑ nausea
- ❑ vomiting
- ❑ diarrhea
- ❑ constipation
- ❑ gas
- ❑ hemorrhoids
- ❑ gall bladder
- ❑ belching
- ❑ heartburn
- ❑ abdominal pain

Gastrointestinal (cont.)
- ❑ bloody/black stools
- ❑ indigestion
- ❑ liver trouble

Skin
- ❑ easy bruising
- ❑ dry skin
- ❑ itching
- ❑ boils
- ❑ rashes
- ❑ excessive sweat
- ❑ hair changes
- ❑ psoriasis
- ❑ acne
- ❑ eczema

Heart/Lung
- ❑ chest pain
- ❑ shortness of breath
- ❑ chronic phlegm

Heart/Lung (cont.)
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ persistent cough
- ❑ hard to breathe
- ❑ coughing blood
- ❑ coughing phlegm
- ❑ irregular heartbeat
- ❑ varicose veins
- ❑ ankle swelling

Reproductive System
- ❑ painful intercourse
- ❑ prostate problems
- ❑ sexual problems
- ❑ loss of sex drive
- ❑ genital infections

Birth control method:

_____

Women Only
- ❑ painful periods
- ❑ PMS
- ❑ bloating
- ❑ heavy periods
- ❑ irregular periods
- ❑ pregnant
- ❑ fibroids
- ❑ ovarian cysts

Date of last period:

_____

# of pregnancies:_____

# of miscarriages:_____

# of abortions:_____

- ❑ difficult labor
- ❑ breast problems

Do you consume or have exposure to the following, explain and include frequency:

Item	Description (i.e. past, current, specific type)	Reaction (i.e. headache, skin rash, muscle/ joint, soreness, abdominal issues)	Servings or frequency per day / week
Artificial Sweeteners			
Soy products			
MSG			
Dairy			
Eggs			
Nuts/Seeds			
Alcohol			
Cigarette Smoke			
Recreational Drugs			
Fast Foods			
Sweets/ Desserts			
Coffee/ Black Tea			
Soda/ Diet soda			

Item	Description (i.e. past, current, specific type)	Reaction (i.e. headache, skin rash, muscle/ joint, soreness, abdominal issues)	Servings or frequency per day / week
Fruit juice			
Sports drinks			
Energy drinks			
Whole grains			
Red meat			
Poultry			
Pork			
Seafood			
Beans/ Legumes			
Vegetables			
Dark leafy Greens			
Whole fresh fruits			
Water			
Other:			

Is there anything else you feel I need to know about you (your health, your life, your preferences, etc.)?