Health History

OFFICE USE ONLY

Name: _____ Date: _____

Birthdate: _____ Age: _____ Sex: ☐ Male ☐ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks

Are you: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

Names and ages of children: _____

How did you hear about the SHAPE Program? _____

What health benefits do you want to achieve with the SHAPE Program?

☐ Improved eating habits ☐ Improved well-being ☐ Decreased inflammation ☐ Weight loss
☐ Increased energy ☐ Improved sleep ☐ Increased stamina ☐ Other _____

Physical Health

Height: _____ Weight: _____

Are there any areas of your body that are not functioning optimally? ☐ Yes ☐ No
If yes, explain: _____

On average, how many hours do you sleep per night? ☐ <5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Do you wake up feeling refreshed? ☐ Always ☐ Sometimes ☐ Rarely ☐ Never

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No
If yes, why and when? _____

Have you been diagnosed with any clinical condition or disease? ☐ Yes ☐ No
If yes, what? _____

Have you ever been in a motor vehicle accident? ☐ Yes ☐ No
If yes, what kind and when? _____
Were you evaluated and treated after the accident? ☐ Yes ☐ No

Have you had any non-vehicle accidents or falls? ☐ Yes ☐ No
If yes, explain: _____

Have you had any imaging performed in the last year? ☐ X-ray ☐ MRI ☐ US ☐ PET ☐ No

Have you had blood work performed in the last year? ☐ Yes ☐ No
Were your test results in medically normal ranges? ☐ Yes ☐ No
If no, which results were abnormal? _____

Food Health

Please list the foods you commonly eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How many cups of vegetables do you eat per day? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

What foods do you crave? _____

What are some specific goals you have regarding the SHAPE Program? _____

_____

Chemical Health

Do you choose to get annual flu shots? ☐ Yes ☐ No

Have you used antibiotics in the last year? ☐ Yes ☐ No

How many cups of water do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many cups of coffee/energy drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

How many glasses of juice/soda/sports drinks do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you eat wheat products (bread/pasta/crackers/baked goods) ? ☐ Yes ☐ No

If yes, how many servings per day? _____

Do you eat refined sugar? ☐ Yes ☐ No

If yes, how many servings per day? _____

Do you ingest artificial sweeteners (Splenda, Aspartame, Equal, diet drinks, gum) ? ☐ Yes ☐ No

Do you have any food/drink allergies, sensitivities or intolerances? ☐ Yes ☐ No _____

Do you smoke? ☐ Yes ☐ No ☐ I used it for: _____ years

Are you/have you been exposed to second-hand smoke? ☐ Yes ☐ No

Do you take probiotics? ☐ Yes ☐ No Do you take Vitamin D? ☐ Yes ☐ No

Do you take Omega-3? ☐ Yes ☐ No Other supplements: _____

Please list any medications that you take regularly and why: _____

_____

_____

Mental/Emotional Health

Rate the current level of **personal stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **relationship stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **health stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **family stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

Rate the current level of **occupational stress** in your life: ☐ None ☐ Low ☐ Moderate ☐ High

How do you manage the stress in your life? _____

I _____ , hereby grant permission to receive a professional and complete physical examination and consultation, including urinalysis and evaluation.

_____ _____

Signature **Date**