BACK TO BASICS HEALTH & NUTRITION

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing *Back To Basics Health & Nutrition* to assist you with your health care. The ability to draw effective conclusions about your state of health and how to optimize its improvement may be influenced by many factors. The information from this form will assist to provide you with an optimal plan of health care.

Date _____

First Name _____ Middle _____ Last_____

Address _____ City _____ State _____ Zip Code_____

Home Phone (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Email _____

Age _____ Date of Birth _____/_____/_____ Place of Birth_____

Gender: ❑ Female ❑ Male

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Long Term Partnership

Genetic Background – please check appropriate box(es):

❑ Caucasian ❑ Native American ❑ African American ❑ Hispanic ❑ Mediterranean ❑ Asian

❑ Other _____

Occupation _____ Hours per week _____

Nature of Business _____

_____

_____

Emergency Contact: _____ Phone _____

Referred by:_____

Name, address, & phone number of primary care physician:_____

_____

CURRENT HEALTH STATUS/CONCERNS Please list any current and ongoing problems.

Problem	Date of Onset	Severity/ Frequency	Treatment Approach	Success
Example: Headaches	May 2012	2 times per week	acupuncture/aspirin	mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

When was the last time that you felt well? _____

What seems to make you feel better? _____

_____

_____

What physician or health care providers (alternative practitioners) have you seen for these conditions?

_____

_____

_____

How much time have you lost from work or school in the past year due to these conditions?

_____

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times
Infancy/Childhood		
Teen		
Adulthood		

How often have you taken steroids (prednisone, cortisone, etc)?	Less than 5 times	More than 5 times
Infancy/Childhood		
Teen		
Adulthood		

List all medications – include all over the counter non-prescription drugs.			
Medication Name	**Date Started**	**Date Stopped**	**Dosage**

List all vitamins, minerals, and any nutritional supplements that you are taking now.			
Type	**Date Started**	**Date Stopped**	**Dosage**

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? ❑ Yes ❑ No

If yes, please list: _____

_____

_____

NUTRITIONAL

FOOD DIARY

Place a check mark next to the food(s)/drink(s) that apply to your current diet.

Usual Breakfast	Usual Lunch	Usual Dinner
❑ None	❑ None	❑ None
❑ Bacon/Sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter
❑ Cereal	❑ Eat in restaurant	❑ Coffee
❑ Coffee	❑ Fish sandwich	❑ Fish
❑ Donut	❑ Fried foods	❑ Fruit
❑ Eggs	❑ Fruit	❑ Juice
❑ Fruit	❑ Hamburger	❑ Margarine
❑ Juice	❑ Hot dogs	❑ Milk
❑ Margarine	❑ Juice	❑ Pasta
❑ Milk	❑ Leftovers	❑ Potato
❑ Sugar	❑ Lettuce	❑ Poultry
❑ Sweet roll	❑ Margarine	❑ Red meat
❑ Sweetener	❑ Mayo	❑ Rice
❑ Tea	❑ Meat sandwich	❑ Salad
❑ Toast	❑ Milk	❑ Salad dressing
❑ Water	❑ Pizza	❑ Soda
❑ Wheat bran	❑ Potato chips	❑ Sugar
❑ Yogurt	❑ Salad	❑ Sweetener
❑ Oat meal	❑ Salad dressing	❑ Tea
❑ Milk protein shake	❑ Soda	❑ Vegetables
❑ Slim fast	❑ Soup	❑ Vinegar
❑ Carnation shake	❑ Sugar	❑ Water
❑ Soy protein	❑ Sweetener	❑ White rice
❑ Whey protein	❑ Tea	❑ Other: (List below)
❑ Rice protein	❑ Vegetables	_____
❑ Other: (List below)	❑ Water	_____
_____	❑ Yogurt	_____
_____	❑ Slim fast	
	❑ Carnation shake	
	❑ Protein shake	

NUTRITIONAL (continued)

How much of the following do you consume <u>each week</u>? (average per week)	
Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of tea containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc.)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? ❑ Yes ❑ No

Are you any of the following:

- ❑ Paleo
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet
- ❑ Other (describe) _____

Is there is anything special about your diet that we should know:

_____

Do you have symptoms immediately after eating, such as belching, bloating, hives, etc? ❑ Yes ❑ No

If yes, are these symptoms with a particular food or supplement? _____

Does skipping meals greatly affect you? ❑ Yes ❑ No

Do you have an aversion to certain foods? ❑ Yes ❑ No

If yes, what food(s) _____

REVIEW OF SYMPTOMS

Check all items that presently apply to you as well as those items that applied to you in the past.

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
GENERAL:			**SKIN (continued):**			**EYES (continued):**		
Fever			Crawling Sensation			Halo around lights		
Chills/Cold all over			Burning on Bottom of Feet			Eye Pains		
Aches/Pains			Athletes Foot			Dark circles under eyes		
General Weakness			Cellulite			Strong light irritates		
Difficulty Sweating			Bugs love to bite you			Cataracts		
Excessive Sweating			Bumps on back of arms & front of thighs			Floaters in eyes		
Swollen Glands			Skin Cancer			Visual Hallucinations		
Cold Hands & Feet			Strong Body Odor			**EARS:**		
Fatigue			Skin sensitive to Sun			Aches		
Difficulty Falling Asleep			Skin sensitive to Fabrics			Discharge/Conjunctivitis		
Sleepwalker			Skin sensitive to Detergents			Pains		
Nightmares			Skin sensitive to Lotions			Ringing		
No Dream Recall			**HEAD:**			Deafness/Hearing Loss		
Early Waking			Poor Concentration			Itching		
Daytime Sleepiness			Confusion			Pressure		
Distorted Vision			Headaches after Meals			Hearing Aid		
SKIN:			Severe Headaches			Frequent Infections		
Cuts Heal Slowly			Migraine Headaches			Tubes in Ears		
Bruise Easily			Frontal Headaches			Sensitive to loud noises		
Rashes			Afternoon Headaches			Hearing Hallucinations		
Pigmentation			Occipital Headaches			**NOSE/SINUSES:**		
Changing Moles			Daytime Headaches			Stuffy		
Calluses			Relieved by eating sweets			Bleeding		
Eczema			Concussion/Whiplash			Running/Discharge		
Psoriasis			Mental Sluggishness			Watery Nose		
Dryness/Cracking Skin			Forgetfulness			Congested		
Oiliness			Indecisive			Infection		
Itching			Face Twitch			Polyps		
Acne			Poor Memory			Acute Smell		
Boils			Hair Loss			Drainage		
Hives			**EYES:**			Sneezing Spells		
Fungus on Nails			Feeling of sand in eyes			Post Nasal Drip		
Peeling Skin			Double Vision			No sense of smell		
Shingles			Blurred Vision			Change of seasons make your symptoms worse		
Nails Split			Poor Night Vision			which season _____		
White Spots/Lines on Nails			See Bright Flashes					

REVIEW OF SYMPTOMS (continued)

Check all items that presently apply to you as well as those items that applied to you in the past.

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
MOUTH:			**CIRCULATION/RESPIRATION (cont.):**			**GASTROINTESTINAL (cont.):**		
Coated Tongue			Dizziness upon standing			Heartburn		
Sore Tongue			Fainting Spells			Acid Reflux		
Teeth Problems			High Cholesterol			Hiatal Hernia		
Bleeding Gums			High Triglycerides			Nausea		
Canker Sores			Wheezing			Vomiting		
T M J			Irregular Heartbeat			Vomiting blood		
Cracked Lips/ Corners			Palpitations			Abdominal Pains/Cramps		
Chapped Lips			Low Exercise Tolerance			Gas		
Fever Blisters			Frequent Coughs			Diarrhea		
Wear Dentures			Breathing Heavily			Constipation		
Grind Teeth when sleeping			Frequently Sighing			Changes in Bowels		
Bite Splint			Shortness of Breath			Rectal Bleeding		
Bad Breath			Night Sweats			Tarry Stools		
Dry Mouth			Varicose Veins/Spider Veins			Rectal Itching		
THROAT:			Mitral Valve Prolapse			Use Laxatives		
Mucus			Murmurs			Bloating		
Difficulty Swallowing			Skipped Heartbeat			Belch Frequently		
Frequent Hoarseness			Heart Enlargement			Anal Itching		
Tonsillitis			Angina Pain			Anal Fissures		
Enlarged Glands			Bronchitis/Pneumonia			Bloody Stools		
Constant clearing of throat			Emphysema			Undigested food in stools		
Throat closes up			Croup			**KIDNEY/URINARY TRACT:**		
NECK:			Frequent Colds			Burning		
Stiffness			Heavy/Tight Chest			Frequent Urination		
Swelling			Prior Heart Attack			Blood in Urine		
Lumps			when_____/_____/_____			Night time urination		
Neck Glands Swell			Phlebitis			Problem passing urine		
CIRCULATION/RESPIRATION:			**GASTROINTESTINAL:**			Kidney Pain		
Swollen Ankles			Peptic/Duodenal Ulcer			Kidney Stones		
Sensitive to hot			Poor Appetite			Painful Urination		
Sensitive to cold			Excessive Appetite			Bladder Infections		
Extremities cold or clammy			Gallstones			Kidney Infections		
Hands/Feet go to sleep/ numbness/tingling			Gallbladder Pain			Syphilis		
High Blood Pressure			Nervous Stomach			Bedwetting		
Chest Pain			Full feeling after small meal			Have trichomonas		
Pain between shoulders			Indigestion					

REVIEW OF SYMPTOMS (continued)

Check all items that presently apply to you as well as those items that applied to you in the past.

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
JOINT/MUSCLES/TENDONS:			**EMOTIONAL (cont.):**			**WOMEN'S HISTORY (women only):**		
Pain wakes you			Often awakened by frightening dreams			Heavy Periods		
Weakness in legs and arms			Family member had nervous breakdown			Spotting		
Balance Problems			Use Tranquilizers			Painful Periods		
Muscle Cramping			Misunderstood by others			Change in Period		
Head Injury			Irritable			Breast soreness before period		
Muscle stiffness in morning			Feeling of hostility/volatile or aggressive			Breast soreness during period		
Damp weather bothers you			Fatigue			Non-period Bleeding		
EMOTIONAL:			Hyperactive			Endometriosis		
Convulsions			Restless Leg Syndrome			Vaginal Dryness		
Dizziness			Considered Clumsy			Vaginal Discharge		
Fainting Spells			Unable to coordinate muscles			Partial/total Hysterectomy		
Blackouts/Amnesia			Difficulty falling asleep			Hot Flashes		
Had prior shock therapy			Difficulty staying asleep			Mood Swings		
Frequently keyed up/ jittery			Daytime sleepiness			Headaches		
Startled by sudden noises			Am a workaholic			Breast Cancer		
Anxiety/Feeling of panic			Have had hallucinations			Ovarian Cysts		
Go to pieces easily			Have considered suicide			Pregnant		
Forgetful			Have overused alcohol			Infertility		
Listless/Groggy			Family history of alcoholism			Decreased Libido		
Withdrawn feeling/Feel 'lost'			Cry often			Heavy Bleeding		
Had Nervous Breakdown			Feel Insecure			Joint Pains		
Unable to concentrate/short attention span			Have overused drugs			Concentration/Memory Problems		
Vision Changes			Been addicted to drugs			Weight Gain		
Unable to reason			Extremely Shy			Loss of Bladder Control		
Considered a nervous person by others			Depressed			Palpitations		
Tends to worry needlessly			Had Psychiatric Care			Fibrocystic Breasts		
Unusual Tension						Fibroid Tumors/Breast		
Frustration			Other:_____			Fibroid Tumors/Uterus		
Emotional Numbness			_____			Lumps in Breast		
Often have cold sweats			_____					
Profuse Sweating								

REVIEW OF SYMPTOMS (continued)

Check all items that presently apply to you as well as those items that applied to you in the past.

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
MEN'S HISTORY (men only)								
Have you had a PSA done? ❑ Yes ❑ No Circle PSA Level: 0 – 2 2 – 4 4 – 10 >10								
Prostate Enlargement			Sore on Penis			Difficulty maintaining an erection		
Prostate Infection			Genital Pain					
Change in Libido			Hernia			Nocturia (urination at night) How many times a night? _____		
Impotence			Prostate Cancer					
Diminished/Poor Libido			Low Sperm Count					
Infertility			Difficulty obtaining erection			Urgency/Hesitancy/Change in Urinary Stream		
Lumps in Testicles			Loss of bladder control					

DENTAL HISTORY

	Yes	No	Comments
Problem with sore gums (gingivitis)?			
Ringing in the ears (tinnitus)?			
Have TMJ (temporal mandibular joint) problems?			
Metallic taste in mouth?			
Problems with bad breath (halitosis) or white tongue (thrush)?			
Previously or currently wear braces?			
Problems chewing?			
Floss regularly?			
Do you have amalgam (silver fillings) dental fillings?			How many? _____
Did you receive these fillings as a child?			
Do you have bleeding gums?			
Do you have root canals?			How many? _____
Do you have tooth implants?			How many? _____
Do you take antibiotics before dental work?			

FEMALE MEDICAL HISTORY *(For women only)*

Check box if yes, and provide number of occurrences of conditions:

❑ Pregnancies_____ ❑ Caesareans_____ ❑ Vaginal Deliveries _____

❑ Miscarriages_____ ❑ Abortions_____ ❑ Living Children_____

❑ Post Partum Depression_____ ❑ Toxemia_____ ❑ Gestational Diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:_____ Length: _____

Painful: ❑ Yes ❑ No Clotting: ❑ Yes ❑ No

Date of last menstrual period: _____/ _____/ _____

Do you currently use contraception? ❑ Yes ❑ No

If yes, what please indicate which form:

Non-hormonal:

❑ Condom
❑ Diaphragm
❑ IUD
❑ Partner vasectomy
❑ Other (non-hormonal-please describe)

_____

Hormonal:

❑ Birth control pills
❑ Patch
❑ Nuva Ring
❑ Other (please describe)

_____

_____

Are you menopausal? ❑ Yes ❑ No If yes, age of menopause _____

Do you currently take hormone replacement products? ❑ Yes ❑ No How long?_____

What type:

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera ❑ Bio-Identical

❑ Other _____

DIAGNOSTIC TESTING

Last Mammogram or Thermography: _____/ _____/ _____

Breast Biopsy? ❑ Yes ❑ No If yes, date: _____/ _____/ _____

Date of last Bone Density: _____/ _____/ _____ Results: ❑ High ❑ Low ❑ Normal range

PAST MEDICAL AND SURGICAL HISTORY Please check all boxes that are appropriate.

ILLNESSES - past or present

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Chronic Fatigue Syndrome
- ❑ Crohn's Disease or Ulcerative Colitis
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy, Convulsions, or Seizures
- ❑ Gallstones
- ❑ German Measles
- ❑ Gout
- ❑ Heart Attack, Angina
- ❑ Heart Failure
- ❑ Hepatitis
- ❑ Herpes Lesions/Shingles
- ❑ High Blood Fats (cholesterol, triglycerides)
- ❑ High Blood Pressure (hypertension)
- ❑ Irritable Bowel (or chronic diarrhea)
- ❑ Kidney Stones
- ❑ Measles
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Pneumonia
- ❑ Rheumatic Fever
- ❑ Sinusitis
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Whooping Cough

INJURIES - past or present

- ❑ Back injury
- ❑ Broken bones or fractures (describe)
- ❑ Head injury
- ❑ Neck injury
- ❑ Other (describe)_____
- ❑ Other (describe) _____

DIAGNOSTIC STUDIES

- ❑ Blood Tests
- ❑ Bone Density Test
- ❑ Bone Scan
- ❑ Carotid Artery Ultrasound
- ❑ CAT Scan (type) _____
- ❑ Colonoscopy
- ❑ EKG
- ❑ Liver Scan
- ❑ Mammogram
- ❑ Neck X-Ray
- ❑ MRI
- ❑ X-Ray (type) _____
- ❑ Other (describe)_____
- ❑ Other (describe) _____

SURGERIES

- ❑ Appendectomy
- ❑ Dental Surgery
- ❑ Gall Bladder
- ❑ Hernia
- ❑ Hysterectomy
- ❑ Tonsillectomy
- ❑ Tubes in Ears
- ❑ Other (describe)_____
- ❑ Other (describe) _____

❑ Other (describe) _____

❑ Other (describe) _____

CHILDHOOD HISTORY Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full term baby				
A premature birth ('preemie')?				
Breast fed?				
Bottle fed?				

Have you been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (candy, cookies, etc.)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? ❑ Yes ❑ No

If yes, please explain: (Example: milk – diarrhea)_____

_____

_____

CHILDHOOD HISTORY (continued)

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	Yes	Age		Yes	Age
ADD (Attention Deficient Disorder)			Measles		
Asthma			Mumps		
Bronchitis			Pneumonia		
Chicken Pox			Seasonal Allergies		
Colic			Skin Disorders (e.g. dermatitis)		
Congenital Problems			Strep Infections		
Ear Infections			Tonsillitis		
Fever Blisters			Upset stomach, digestive		
Frequent Colds or Flu			Whooping cough		
Frequent Headaches			Other (describe below)		
Hyperactivity					
Jaundice					

As a child did you:

Have a high absence from school? ❑ Yes ❑ No

If yes, please explain _____

_____

_____

Experience chronic exposure to second hand smoke in your home? ❑ Yes ❑ No

Experience abuse? ❑ Yes ❑ No

If yes, please explain _____

_____

_____

Have substance abusive (drugs/alcohol) parents? ❑ Yes ❑ No

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? ❑ Yes ❑ No

If yes, what type? ❑ Cigarette ❑ Smokeless ❑ Cigar ❑ Pipe ❑ Patch/Gum

How much? _____

Number of years? _____ If not a current user, year quit _____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? ❑ Yes ❑ No

If yes, please explain:_____

_____

ALCOHOL INTAKE

Have you ever used alcohol? ❑ Yes ❑ No

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) ❑ Yes ❑ No

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

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

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? ❑ Yes ❑ No

If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? ❑ Yes ❑ No

If yes, indicate which metals:

- ❑ Lead
- ❑ Cadmium
- ❑ Arsenic
- ❑ Mercury
- ❑ Aluminum

LIFESTYLE HISTORY (continued)

Average number of hours that you sleep at night? ❑ less than 6 ❑ 6-8 ❑ 8-10 ❑ more than 10

Do you:
- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?

Do you exercise regularly? ❑ Yes ❑ No

If yes, please indicate: Type of exercise	**Times/Week**				**Length of Session**			
	1x	**2x**	**3x**	**4x/+**	**≤15 min**	**16-30 min**	**31-45 min**	**>45 min**
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please list below) _____								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc.)

_____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health.

Are you overall happy? ❑ Yes ❑ No

Do you feel you can easily handle the stress in your life? ❑ Yes ❑ No

If no, do you believe that stress is presently reducing the quality of your life? ❑ Yes ❑ No

If yes, do you believe that you know the source of your stress? ❑ Yes ❑ No

Comments _____

SOCIAL HISTORY (continued)

Do you practice meditation or relaxation techniques? ❑ Yes ❑ No How often? _____

Check all that apply: ❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer

❑ Other _____

Hobbies and leisure activities: _____

READINESS ASSESSMENT

Rate on a scale of 1 to 5

1=not willing 5=very willing

In order to improve your health, how willing are you to:

Significantly modify your diet if necessary	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Take nutritional supplements each day	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Keep a record of everything you eat each day	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Modify your lifestyle (e.g. work demands, sleep habits)	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Practice relaxation techniques	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5
Engage in regular exercise	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5

Comments_____

_____

_____

What is your primary health concern?