Restoring Our Health
one bite at a time

# Health History

**Last Name:** _____ **First Name:** _____ **Middle Initial:** _____

**Address:** _____ **Apartment #:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Home #:** _____ **Cell #:** _____ **Ok to receive text messages?** _____

**Email:** _____

**How did you find us?** Patient *(who)* : _____ Doctor *(who)* : _____ Staff *(who)* : _____

**Date of Birth:** ____/____/____ **Gender** (*circle one*): ☐Male ☐Female **Marital Status** (*circle one*): ○M ○D ○W ○S

**Age:** _____ **Height:** _____ **Current weight:** _____ **Weight 6 months ago:** _____

**Employer:** _____ **Work #:** _____ **Ext:** _____

**Emergency Contact:** _____ **Relationship:** _____ **Phone #:** _____

**Relationship status:** _____ **Children:** _____ **Pets:** _____

**Are you currently taking any medications or supplements?** (*Please include regularly used over the counter medications*).....

| Prescription Medication Name | Dosage and Frequency | Date Started |
|---|---|---|
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| Supplements (including brand name) | Dosage and Frequency |
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**Do you have any medication, food, or seasonal allergies?**

| Medication, Food or Seasonal Allergies | Reaction |
|---|---|
| | |
| | |
| | |

| Medication, Food or Seasonal Allergies | Reaction |
|---|---|
| | |
| | |
| | |

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# Health History

Please list your main health concerns: _____

Please list your 3 main health & fitness goals: _____

At what point in your life did you feel best and why? _____

Please list any illnesses, including autoimmune diseases: _____

Please list any hospitalizations or injuries: _____

Have you ever had an eating disorder? _____

How is/was the health of your mother? _____ How is/was the health of your father? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Do you take anything to help you sleep? _____

## WOMEN'S HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

Reached or approaching menopause? Please explain: _____

Birth control history: _____

Do you experience yeast infections or urinary tract infections? Please explain: _____

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**Please list any current symptoms, such as pain, digestion issues, etc:**

**What have you tried in the past to achieve your nutrition and fitness goals? This includes any diet, supplements, books, etc.**

**What are the things you visualize yourself doing once you are healthy?**

**RATE YOUR MOVEMENT**

| | None | Some | Always |
|---|---|---|---|
| Climbing Stairs | ○ | ○ | ○ |
| Computer work | ○ | ○ | ○ |
| Dressing | ○ | ○ | ○ |
| Driving/riding in cars | ○ | ○ | ○ |
| Exercise | ○ | ○ | ○ |
| Riding a bike | ○ | ○ | ○ |
| Stretching or yoga | ○ | ○ | ○ |
| Aerobic activity | ○ | ○ | ○ |

| | None | Some | Always |
|---|---|---|---|
| Housework | ○ | ○ | ○ |
| Running | ○ | ○ | ○ |
| Sitting | ○ | ○ | ○ |
| Taking care of child | ○ | ○ | ○ |
| Walking | ○ | ○ | ○ |
| Yard work | ○ | ○ | ○ |
| Lifting weights | ○ | ○ | ○ |

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What is your story? Take time to reflect on your life events from birth to the present time. What have your life events been? Start with birth moving through the life stages. Some examples are a difficult birth, accidents, marriage, divorce, deaths, starting a business, job changes, and financial issues.

BIRTH TO 15 YEARS: _____

15 TO 30 YEARS: _____

30 TO 40 YEARS: _____

40 TO 50 YEARS: _____

50+ YEARS: _____

## MY HYDRATION

What is your average daily intake? (oz.)

Water _____ Juice _____

Caffeine _____ Energy Drinks _____

Soft Drinks _____ Milk _____

Alcohol _____ Other (write in) _____

## LABS & TESTING

In the past 3 years have you had these things checked:

Blood pressure: _____ Mammogram _____

Cholesterol: _____ Pap or pelvic exam: _____

Vitamin D level: _____ Omega 3's: _____

Lab work: _____ Date of lab work: _____

Please bring any recent copies of lab work to your appointment.

## MY FUEL

Do you eat the following foods daily, weekly, monthly or never?

- **Processed Foods** (cereal, bread, crackers, etc.) ○ Daily ○ Weekly ○ Monthly ○ Never
- **Fast Food** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Grains** (wheat, rice, corn, etc.) ○ Daily ○ Weekly ○ Monthly ○ Never
- **Good Fats** (avocado, coconut oil, nuts & seeds, etc.) ○ Daily ○ Weekly ○ Monthly ○ Never
- **Vegetables** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Fruit** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Dairy** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Beef** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Pork** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Chicken** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Fish** ○ Daily ○ Weekly ○ Monthly ○ Never
- **Eggs** ○ Daily ○ Weekly ○ Monthly ○ Never

## MY MEDICAL PRACTICES

Mark the wellness disciplines you use.

- ○ Acupuncture
- ○ Chiropractic
- ○ Dental Care
- ○ Exercise / Movement Classes
- ○ Eye Care
- ○ General Medical
- ○ Massage Therapy
- ○ Meditation / Prayer
- ○ Nutritional Counseling
- ○ Psychological Counseling
- ○ Yoga

Circle the appropriate number 0-3 on all questions below. 0 as the least/never to 3 as the most/always.

## DIGESTION

Alternating constipation and diarrhea ..... 0 1 2 3
Diarrhea ..... 0 1 2 3
Constipation ..... 0 1 2 3
Coated tongue or "fuzzy" debris on tongue ..... 0 1 2 3
Frequent use of laxatives ..... 0 1 2 3
Stomach pain, burning or aching 1-4 hours after eating ..... 0 1 2 3
Feeling hungry an hour or two after eating ..... 0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages ..... 0 1 2 3
Bitter metallic taste in mouth, especially in the morning ..... 0 1 2 3
Unexplained itchy skin ..... 0 1 2 3
Stool color alternates from clay colored to normal brown ..... 0 1 2 3
Excessive belching, burping or bloating ..... 0 1 2 3
Difficulty digesting fruits/vegetables; undigested foods found in stools ..... 0 1 2 3
Roughage and fiber cause constipation ..... 0 1 2 3
Frequent urination ..... 0 1 2 3
Increased thirst and appetite ..... 0 1 2 3
History of gallbladder attacks or stones ..... 0 1 2 3
Have you had your gallbladder removed? ..... yes no

## NERVOUS SYSTEM

Have difficulty falling asleep ..... 0 1 2 3
Have difficulty staying asleep; wake tired ..... 0 1 2 3
Get ill often ..... 0 1 2 3
Numbness and/or tingling in hands or feet ..... 0 1 2 3
Frequent Headaches ..... 0 1 2 3
Limited flexibility ..... 0 1 2 3
History of severe falls ..... 0 1 2 3
Have poor concentration ..... 0 1 2 3
Wake up with pain ..... 0 1 2 3
Go to bed with pain ..... 0 1 2 3
Take over-the-counter pain medication ..... 0 1 2 3
Take prescription pain medication ..... 0 1 2 3
Multiple Accidents (car, bike, abuse) ..... 0 1 2 3
Have a condition that is unidentified by my medical doctor ..... 0 1 2 3

## BLOOD SUGAR

Crave sweets during the day ..... 0 1 2 3
Irritable if meals are missed ..... 0 1 2 3
Depend on coffee to keep yourself going or started ..... 0 1 2 3
Eating relieves fatigue ..... 0 1 2 3
Agitated, easily upset, nervous ..... 0 1 2 3
Poor memory, forgetful ..... 0 1 2 3
Blurred vision ..... 0 1 2 3
Must have sweets after meals ..... 0 1 2 3

# Food & Digestion

**How was your weight as a child? Were you average weight or heavier?** _____

_____

**Has your weight fluctuated over the years? In your opinion, at what weight do you feel healthiest?** _____

_____

**What are you favorite fruits?** _____

_____

**What are your favorite veggies?** _____

_____

**Are there any foods you simply cannot eat or don't like?** _____

_____

**What is your food like these days?**

| Breakfast | Lunch | Dinner | Snacks | Liquids |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?** _____

**Do you cook?** _____ **What percentage of your food is home-cooked?** _____

**Where do you get the rest from?** _____

**Do you currently smoke or have you ever smoked cigarettes? If so, when and how long?** _____

**Do you crave sugar, salt, or coffee? Please list them in order of your preference:** _____

_____

**The most important thing I should do to improve my health is:** _____

_____

# Disclaimer of Liability

Jackie Caldwell is not a physician or a psychologist, and the scope of her consultation services does not include treatment or diagnosis of specific illnesses or disorders. If you, the client, suspect you may have an ailment or illness that may require medical attention, then you are encouraged to consult with a licensed physician without delay.

Rather than dealing with treatment of disease, Jackie Caldwell focuses on wellness and prevention of illness through the use of non-toxic, natural nutritional therapies to achieve optimal health. Jackie Caldwell primarily educates and motivates clients to assume more personal responsibility for their health by adopting a healthy lifestyle and diet.

By signing below, you acknowledge that you understand that Jackie Caldwell is a nutrition consultant and not a physician and cannot diagnose or treat an illness.

Additionally, you promise to give Jackie Caldwell a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

**Cancellation Policy:** I understand that sometimes our lives and schedules can get hectic and unexpected things occur. However, in order to be fair to all of my clients, I kindly ask that you be considerate and value your appointment by showing up on time.

Unless you have an emergency, I ask for 24 hours notice to cancel or reschedule. This gives me an opportunity to fill your appointment with clients on my waitlist.

Thank you for your cooperation.

**Client's Signature**_____ **Date**_____