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:** ☐ Male ☐ Female **Marital Status:** ○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

Supplements (including brand name)	Dosage and Frequency

Do you have any medication, food, or seasonal allergies?

Medication, Food or Seasonal Allergies	Reaction

Do you take over the counter pain relievers? (Advil, Tylenol, Aleve)

If yes, which one and how many a day?

_____

_____

_____

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, depression or mental health issues. Please provide details.

Please list any hospitalizations or injuries:

Have you ever had an eating disorder? If yes, please provide details.

Do you use laxatives? If yes, please provide details.

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:

Health History

DIGESTION:

Bowel movements - How many a day? _____ Diarrhea - How many times a day? _____ Sense of urgency? Yes ☐ No ☐

Constipation? Yes ☐ No ☐ Blood in stool? Yes ☐ No ☐

How many bowel movements in a week?_____

Stomach pain, burning or aching 1-4 hours after eating? Yes ☐ No ☐ Excessive belching, burping or bloating? Yes ☐ No ☐

Difficulty digesting fruits/vegetables, undigested food found in stools? Yes ☐ No ☐

History of gallbladder attacks or stones? Yes ☐ No ☐ Have you had your gallbladder removed? Yes ☐ No ☐

Coated tongue or "fuzzy" debris on tongue? Yes ☐ No ☐ Do you experience bad breath or halitosis? Yes ☐ No ☐

How long have you been experiencing these digestive symptoms? _____

Please list any current symptoms you are having now: pain, (please list specific areas of pain) digestive dysfunction, skin disorders, fatigue.

BLOOD SUGAR:

Crave sweets during the day? Yes ☐ No ☐ Irritable if meals are missed? Yes ☐ No ☐

Depend on coffee to keep yourself going or started? Yes ☐ No ☐ Eating relieves fatigue? Yes ☐ No ☐

Agitated, easily upset, nervous? Yes ☐ No ☐ Poor memory, forgetful? Yes ☐ No ☐

Blurred vision? Yes ☐ No ☐ Must have sweets after meals? Yes ☐ No ☐

What have you tried in the past to achieve your nutrition and fitness goals? This includes any diet, supplements, books, etc. Did you find any of these things to work well for you?

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

PHYSICAL ACTIVITY:

Do you consider yourself sedentary or active? _____

Is your job sedentary? Yes☐ No☐ N/A☐

Do you exercise regularly? Yes☐ No☐

If yes, what is your form of exercise and how often? This can include gardening, housework, etc.

COOKING

What oils do you use to cook? _____

What flour do you use? _____

Do you have the following cooking tools?

1. Blender Yes☐ No☐ What Kind _____
2. Crock-Pot Yes☐ No☐
3. InstantPot or Pressure cooker Yes☐ No☐
4. Immersion Blender Yes☐ No☐
5. Air Fryer Yes☐ No☐
6. Food Processor Yes☐ No☐

Does your current cookware have Teflon? _____

What type of cookware do you use? _____

Health History

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 _____

Type: Diet ☐ Regular ☐ Other (write in) _____

Alcohol _____

Type: Liquor ☐ Wine ☐ Beer ☐

LABS & TESTING

When is the last time you had a wellness check with your doctor that included labs? _____

Have you had food sensitivity testing done? Yes ☐ No ☐

Have you had your Vitamin D checked? Yes ☐ No ☐

If yes, what is your Vitamin D level: _____

Have you had your Omega 3's checked? Yes ☐ No ☐

If yes, what is your Omega 3's level: _____

Please bring any recent copies of lab work to your appointment or send ahead of time.

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 HEALTH 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

Food & Digestion

How was your weight as a child? Were you average weight, underweight or overweight?

Has your weight fluctuated over the years? Yes ☐ No ☐ In your opinion, at what weight do you feel healthiest? _____

List foods that you know cause digestive issues for you: _____

How many meals do you eat a day? _____ What times do you typically eat your meals? _____

Do you sit down while eating? Yes ☐ No ☐ How many people are you cooking for? _____

What are your favorite fruits and vegetables?

Do you buy organic or conventional produce? _____

Do you buy grass-fed beef? Yes ☐ No ☐ Pasture-raised chicken? Yes ☐ No ☐ Pasture-raised eggs? Yes ☐ No ☐

Wild caught fish? Yes ☐ No ☐ Pasture-raised pork? Yes ☐ No ☐

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 of your food from? _____

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

Do you crave sugar, salt, alcohol 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.

Please make every effort to keep your appointments and notify the office at least 48 hours prior to cancellation. Although we understand that things come up, we miss the opportunity to help another patient with late cancellations or failing to show without advanced notice. A fee of $75 will be charged.

Thank you for your cooperation.

Client's Signature_____ **Date**_____