

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 Choose not to disclose

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

Employer: _____ Work : _____ Ext: _____

Emergency Contact: _____ Relationship: _____ Phone : _____

Relationship status: Single Children: _____ Pets: _____

Married

Partnered

Separated

Divorced

Widowed

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

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

Prescription Medication Name	Dosage	Directions & Time of day	Date Started

Supplements (including brand name)	Dosage	Directions & Time of day	Date Started

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:

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, walking 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? _____

What is your story? Take time to reflect on your life events from birth to the present time. What have your significant 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.

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 normally 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 like to cook and/or bake? _____ 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 _____