Jessica Berliner, MS

Confidential Health History Questionnaire

Patient Name: ____ **Date**: ____________

PLEASE PRINT (Last) (First) (Middle)

*Natural medical healthcare is possible only when the practitioner completely understands the patient's physical, mental and emotional condition. The information you provide helps the nutritionist understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything you have a question about.

Address: ______________________________
STREET/ PO Box

____
CITY, STATE, ZIP

Phone: ______________________________
–
HOME

____
MOBILE

Email
____

Date of Birth: ______________ Age: ___________

Gender M / F

Occupation: ______________________________

How many children do you have? ________________

Relationship Status ☐ Single ☐ Married
☐ Separated ☐ Divorced
☐ Other ________________

With whom do you live? ☐ Spouse ☐ Friends
☐ Parents ☐ Alone ☐ Children
☐ Other ____________________

In your opinion, what are your most important physical, emotional or mental health concerns? Indicate which are of the most immediate concern to you.
(List primary healthcare concern first)

1. ______________________________
Date of onset: _______________

2. ______________________________
Date of onset: _______________

3. ______________________________
Date of onset: _______________

Who is your primary health care physician?

____
NAME PHONE (IF KNOWN)

Patient (or Guardian)

Signature______________________________

Date_______________

Relationship to Patient (if other than self):________________________

MEDICATIONS AND SUPPLEMENTS

What medications (prescribed) are you currently taking?

Name	Dose	Name	Dose

What supplements, herbs, vitamins, etc… are you taking?

Name	Brand	Dose	Reason

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Check each that you currently use on a regular basis:

- ☐ Laxatives
- ☐ Pain relievers
- ☐ Antacids
- ☐ Cortisone
- ☐ Antibiotics
- ☐ OTC Allergy Medication
- ☐ Sleeping pills
- ☐ Birth Control Pills

ALLERGIES

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

GENERAL

Height:	Weight: ________ lbs	Weight 1 yr ago ________ lbs	Personal ideal weight? ______________ lbs	Max weight: _________ lbs	When?
Do you want help modifying your weight?		Yes No	If so, what is your weight loss/gain goal? _________ lbs		
Do you cook at home?		Yes No	How often do you eat out? ________ x week or _________ x month		
What is your favorite food?			Are there any foods that you will not eat?		
How is your energy?		When is it best?	When is it worst?	Is this a change? Yes No	
How is your appetite?				Is this a change? Yes No	
How is your mood?				Is this a change? Yes No	
How is your sleep?				Is this a change? Yes No	
#____ Hours of sleep per night	Do you wake up feeling rested?		Yes No	Is this a change? Yes No	
Do you have supportive relationships?		Yes No	Who?		
Do you exercise?	Yes No		If so, what kind of exercise?	How often? ___________ x per week For how long? _________ min/hours	
How would you describe your relationship with your body?					

Diet (Please tell me about your typical daily choices)

Breakfast:	
Lunch	
Dinner	
Snacks:	

Water ______ cups/oz	Coffee ______ cups	Herbal Tea ______ cups	Black Tea ______ cups	Soda ______ cups/oz
Energy drinks ______ oz	Wine ______ oz	Beer ______ oz	Liquor ______ oz	Mixer ______ cups/oz

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Please list the most significant stressful events of your life (remember to include childhood):

1. ____

2. ____

3. ____

FAMILY HISTORY

Number of Siblings:

Check all that Apply	Mother	Father	Grandparent	Sister/ Brother	Spouse	Children
AIDS						
Alcoholism						
Allergies						
Alzheimer's						
Anemia						
Arthritis						
Asthma						
Cancer						
Diabetes						
Epilepsy						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Liver Disease						
Mental Illness						
Stroke						
Substance Abuse						
Thyroid Problems						
Other (write in please)						

Answer questions or check any of the following you have or have had.

- □ History of abuse
- □ Major traumas
- □ Eat on the go
- □ Emotionally eat
- □ Binge eat
- □ Treated for an eating disorder? When? ________________
- □ Eat late at night
- □ Eat refined sugar
- □ Do you have food cravings? What kind ____________________
- □ Enjoy your work
- □ Take vacation
- □ Spend time outside

- □ Treated for alcoholism When? ____________________
- □ Use recreational drugs Type? ______________________
  How often? ____________________
- □ Treated for drug dependence When? ____________________
- □ Use tobacco currently? How many packs per day? _________
- □ Used tobacco in the past How many years? _________

Anything else you would like me to know about you?

____

____