Health Evaluation Profile 1

Name_____Date_____

Address_____City_____State____Zip_____

Phone: (day)_____(night)_____E-mail_____

Height_____Weight_____Body Frame_____Blood Type_____

Birthdate_____Children?_____How many?_____

Pregnancy: Easy or difficult?_____

Occupation_____

Exercise/Recreation_____

_____

_____

Health Concerns

List your five major health concerns at this time_____

_____

_____

_____

_____

_____

Describe the onset and occurrence of health problems in detail (use a separate sheet if necessary)_____

_____

_____

_____

_____

_____

_____

Have you dealt with these concerns in the past (doctors, self-care, etc.)?

List any medicine or supplements you are currently taking for these or other health problems as well as for improving and maintaining health status.

Have any other family members had similar problems? (describe)

Family Health History: Any other health issues? (diabetes, heart disease, thyroid disease, cancer, etc.)

Condition of hair: (thinning, losing any, dry, etc.)

Nails: (white spots, ridges, cracks, thin, break easily, strong, grow easily, etc.)_____

_____

Sleep: (fall asleep, stay asleep, wake up during the night, insomnia, wake up early, sleep short hours, etc.)_____

_____

_____

How would you rate your levels of stress in the following areas: (1-10 with ten indicating high levels of stress)

a. Work_____
b. Family_____
c. Relationships_____
d. Environmental (allergies and toxic exposures)_____
e. Financial_____
f. Other (describe_____

How has your diet changed in relationship to your health concerns? (special diets, etc.)_____

_____

_____

_____

_____

Describe the foods you eat (comfort foods) when you are:

a.	Hungry	c.	Lonely	e.	Depressed
b.	Angry	d.	Tired	f.	Celebrating