Health History

OFFICE USE ONLY

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

How do you prefer to be contacted? ☐ Phone ☐ Text ☐ Email Occupation: _____

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female Height (ft): _____ Weight (lbs): _____

How did you hear about the SHAPE Program? _____

BLOOD WORK: If you have recent blood work (within the last 6 months), please include a copy with this form.

QUESTIONNAIRE

What are your three most important current health concerns?

1. _____
2. _____
3. _____

List any medical problems currently being managed by a physician: _____

_____

_____

List any surgeries with dates: _____

_____

_____

List any allergies to food, drugs or other known allergies: _____

_____

_____

List all supplements you are taking on a routine (daily - monthly) basis, include dose: _____

_____

_____

List all prescription and over-the-counter drugs you are taking on a routine (daily - monthly) basis: _____

_____

_____

Have you tried the SHAPE Program previously? If so, when? _____

What was/wasn't successful about the SHAPE Program? _____

_____

What other programs have you tried? _____

_____

What was/wasn't successful about the other program(s)? _____

_____

What are the main stresses in your life? _____

_____

Have you experienced any life-changing stressful events? _____

_____

What do you do to de-stress?_____

_____

What are some of your hobbies? _____

_____

Why do you want to do the SHAPE Program? _____

_____

What is your activity level on a scale from 1-10? (10 being very active) _____

What is your average energy level on a scale of 1-10? (10 being the optimal energy level you think you *should* have) _____

Do you feel you get adequate sleep?	☐ Yes ☐ No	_____
Do you wake rested?	☐ Yes ☐ No	_____
Do you wake during the night? At what time?	☐ Yes ☐ No	_____
Do you sleep next to any electronic devices?	☐ Yes ☐ No	_____
Do you exercise?	☐ Yes ☐ No	_____
Do you follow any particular diet?	☐ Yes ☐ No	_____
Do you consume caffeine daily?	☐ Yes ☐ No	_____
Do you use tobacco?	☐ Yes ☐ No	_____
Do you consume alcohol?	☐ Yes ☐ No	_____
Do you feel you've ever had a problem with overuse of drugs or alcohol?	☐ Yes ☐ No	_____
Do you have a good support system?	☐ Yes ☐ No	_____
Do you have a spiritual practice?	☐ Yes ☐ No	_____

SYMPTOMS/CONDITIONS

Check the boxes of symptoms/conditions that you have experienced over the last 6 months.

Wood:

- ☐ Back pain
- ☐ Brittle nails
- ☐ Bursitis/Tendonitis
- ☐ Headaches/Migraines
- ☐ Gallbladder problems
- ☐ Gout
- ☐ Irritable/Angry
- ☐ Hepatitis/Liver disease
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Muscle weakness
- ☐ Paralysis

Fire:

- ☐ Anxiety
- ☐ Bleed or bruise easily
- ☐ Chest pain/pressure
- ☐ Depression
- ☐ Environmental sensitivities
- ☐ Fainting/Dizziness
- ☐ Food intolerances
- ☐ Heart disease
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Hot/Cold intolerance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Insomnia
- ☐ Palpitations
- ☐ Memory loss
- ☐ Nose bleeds
- ☐ Numbness/Tingling
- ☐ Seizures/Epilepsy
- ☐ Tremors
- ☐ Varicose veins

Earth:

- ☐ Acid reflux
- ☐ Abdominal Pain
- ☐ Cold/Canker sores
- ☐ Diabetes
- ☐ Excessive thirst/hunger
- ☐ Gas/Bloating
- ☐ Hemorrhoids
- ☐ Hypoglycemia
- ☐ Indigestion
- ☐ Insulin resistance
- ☐ Irritable when hungry
- ☐ Nausea/Vomiting
- ☐ Tired after eating
- ☐ Ulcers
- ☐ Worrisome

Metal:

- ☐ Acne
- ☐ Asthma
- ☐ Constipation
- ☐ Cough
- ☐ Despair/Apathy
- ☐ Diarrhea
- ☐ Eczema
- ☐ Emphysema
- ☐ Gingivitis
- ☐ Hay fever
- ☐ Hives
- ☐ Psoriasis
- ☐ Rashes/Itchiness
- ☐ Respiratory infections
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin tags
- ☐ Wheezing/Hoarseness

Water:

- ☐ Arthritis
- ☐ Chronic urinary tract infections
- ☐ Dentures
- ☐ Edema
- ☐ Excess libido
- ☐ Fearful
- ☐ Frequent ear infections
- ☐ Hair loss
- ☐ Hearing loss
- ☐ Incontinence
- ☐ Infertility
- ☐ Joint pain
- ☐ Kidney stones
- ☐ Low blood pressure
- ☐ Low libido
- ☐ PMS
- ☐ Prostate issues
- ☐ Ringing in ears

Other:

- ☐ Autoimmune disease
- ☐ Bleeding gums
- ☐ Employment difficulties
- ☐ Erectile dysfunction
- ☐ Children (list age) _____
- ☐ Hernia
- ☐ History of abuse
- ☐ History of antibiotic use
- ☐ History of vaccine reactions
- ☐ Relationship problems
- ☐ Restless legs
- ☐ Schizophrenia
- ☐ Serious head injury
- # Bowel movements/day _____

Women Only:

- ☐ Breast masses
- ☐ Hysterectomy
- ☐ Irregular periods
- ☐ Lack of periods
- ☐ Menopause (age) _____
- ☐ Painful/Heavy periods
- ☐ Spotting
- ☐ Vaginal discharge
- ☐ Yeast infections

☐ Pregnancies #_____ ☐ C-section #_____ ☐ Miscarriage #/date _____

Are you/Do you plan to become pregnant? ☐ Yes ☐ No _____

Are you breastfeeding? ☐ Yes ☐ No _____

Are you taking birth control? What kind? ☐ Yes ☐ No _____

Are you on hormone replacement therapy? ☐ Yes ☐ No _____

INFORMED CONSENT

I, _____, understand that the SHAPE Program is a lifestyle modification, health restoration program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary healthcare experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dose adjustments. I agree to notify my prescribing physician that I am working with _____ and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutrition protocol will be recommended based on my unique health history, urinalysis and symptoms.

NOTES (Practitioner only)

_____

_____

_____

_____

_____

SHAPE ReClaimed