



Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone: Home: _____ Work: _____ Mobile: _____

Age: _____ Height: _____ Birthdate: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Why did you come for a Health History? _____

SOCIAL INFORMATION

Relationship status: _____ Spouse name: _____

Children: _____ Children(s) name(s): _____

Where do you currently live? _____ Pets: _____

Occupation: _____ Hours of work per week: _____

HEALTH INFORMATION

Please list your main health concerns: _____

Other concerns and/or goals? _____



Senior Health History

HEALTH INFORMATION (continued)

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries? _____

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry? _____ What blood type are you? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness, or swelling? _____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

MEDICAL INFORMATION

Do you take any supplements or medications? Please list: _____

Any healers, helpers, or therapies with which you are involved? Please list: _____

What role does exercise play in your life? _____

What is your energy like? _____

Do you still feel independent? Please explain: _____

Are you part of a community? Please explain: _____



Senior Health History

FOOD INFORMATION

Please list what you eat (the most commonly eaten foods on a daily basis):

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

The most important thing I should do to improve my health is: _____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

Toxicity QUESTIONNAIRE

INTEGRATIVE WELLNESS ADVISORS

The Toxicity Questionnaire is a short self-assessment that will help you determine how toxic your body is now, based on the symptoms or conditions you're experiencing. This is your toxicity score "base case."

You may find it helpful to take this questionnaire again every 1-3 months to determine what (if anything) has changed. This comparison will give you valuable information about how your body is reacting to changes in your diet and lifestyle over time.

Respond "yes" or "no" to each question (keep in mind: "maybe" counts as "yes") based on your experience for the past 60 days.

- | | |
|--|---|
| <input type="checkbox"/> Sugar cravings? | <input type="checkbox"/> Chest congestion? |
| <input type="checkbox"/> Hunger that's difficult to satisfy? | <input type="checkbox"/> Asthma or wheezing? |
| <input type="checkbox"/> Low or inconsistent energy? | <input type="checkbox"/> Migraines or headaches? |
| <input type="checkbox"/> Fatigue, especially after exercise? | <input type="checkbox"/> Ringing in ears? |
| <input type="checkbox"/> Constipation? | <input type="checkbox"/> Depression? |
| <input type="checkbox"/> Difficulty sleeping restoratively? | <input type="checkbox"/> Anxiety? |
| <input type="checkbox"/> Caffeine addiction? | <input type="checkbox"/> Mood swings? |
| <input type="checkbox"/> Bloating or gas? | <input type="checkbox"/> Irritation? |
| <input type="checkbox"/> Reflux or heartburn? | <input type="checkbox"/> Brain fog or difficulty with concentration? |
| <input type="checkbox"/> Irritable bowel? | <input type="checkbox"/> Distractibility? |
| <input type="checkbox"/> Difficulty losing weight? | <input type="checkbox"/> Skin problems, such as acne, rosacea, eczema, or rashes? |
| <input type="checkbox"/> Binge eating or drinking? | <input type="checkbox"/> Joint problems or pain? |
| <input type="checkbox"/> Fluid retention? | <input type="checkbox"/> Muscle aches? |
| <input type="checkbox"/> Stuffy or runny nose, itchy nose or eyes? | |

Total score _____

Today's date _____