Health History Form

Personal Information

Name:
Address:
Email:
Phone:
Work Phone:
Age:

Birthday:
Height:
Current Weight:
Weight 6 months ago:
Weight 1 yr ago:

Social Information

Relationship Status:
Occupation:
Days per week of work:

Children:
Hours per week of work:
Hours per day of work:

Give a general description of the following

1. Typical work day- time of day wake up?
   Typical times of day you eat or snack?
   Time of your last meal?

   Time you eat Breakfast?
   Do you exercise on work days?
   How long till bed after last meal?

2. Typical off day- time of day wake up?
   Typical times of day you eat or snack?
   Time of your last meal?

   Time you eat breakfast?
   Do you exercise on off days?
   How long till bed after last meal?

Health information

Any Serious illness/ hospitalizations/ injuries?
How is the health of your parents?
Do you sleep well Y/N how many hours? Do you wake up at night? Reason?

Medical Information

Do you take any supplements or medications? Explain
What is your activity level like? (i.e. rec. sports, cardio, resistance training)
What time of days are you exercising? Duration? Times per week?

Food Information

Food allergies or sensitivities? Explain (IBS/gas/constipation)
In general what do you eat at Breakfast?
" Lunch?
" Dinner?
" Snacks?
" Liquids? (all)
Do you cook?
What percentage of your food is home cooked?
What do you crave or binge on? (sweets, coffee, dairy, salty,)
Do you have any major addictions? (alcohol, cigarettes)