**Personal Health Evaluation**

1. **Personal Information**

Name: Date:

Street Address: Phone:

City, State, Zip: Referred By:

Age & Sex: Height: Weight: Blood Type:

1. **Diet, Nutrition & General Health Practices**
2. How often do you consume the following? (1= Very Frequently, 2= Often, 3= Rarely, 4= Never)

Refined Sugar: Dairy Products: Fresh Fruits:

White Flour: Pork/Shellfish: Vegetables:

Alcohol: Red Meat: Green Salads:

Fried Foods: Chicken/Turkey: Whole grains:

Caffeine Drinks: Artificial Sweeteners: Fresh Fish:

1. How much water do you drink each day? Cups.

What kind of water do you drink?

1. How much sleep do you get each night on the average?

How do you sleep?

1. How often do you exercise?

What do you do for exercise?

1. What is your energy level like?
2. How often do your bowels eliminate?
3. Do you feel like you are under stress? If so, explain.
4. What nutritional supplements are you currently taking?
5. **Medical Information**
6. What are your current health concerns?
7. List any serious illnesses or surgeries you have had in the past.
8. Are you under a medical doctor’s care for your condition?

If so, what medications, drugs or therapies are you currently using?

1. What medications, medical procedures, supplements or therapies have you previously tried for your condition? Were any of these supplements or therapies helpful? If so, please note which ones were helpful.
2. Additional comments or helpful information, if any.