

# Personal Health Inventory

## I. Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Day: \_\_\_\_\_ Evening: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address \_\_\_\_\_

Occupation \_\_\_\_\_

DOB \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referred by: \_\_\_\_\_

How did you hear about my services?

Yellow Pages/Internet/Advertisement/Word of mouth/Client Referral \_\_\_\_\_

## II. Diet, Nutrition, and General Health

a. How often do you consume the following? (1=Very Frequently, 2=Often, 3=Rarely, 4=Never)

Refined Sugar	1 2 3 4	Dairy Product	1 2 3 4	Fresh Fruits	1 2 3 4
White Flour	1 2 3 4	Pork/Shell Fish	1 2 3 4	Vegetables	1 2 3 4
Alcohol	1 2 3 4	Red Meat	1 2 3 4	Green Salads	1 2 3 4
Tobacco/Smoking	1 2 3 4	Poultry	1 2 3 4	Whole Grains	1 2 3 4
Caffeine drinks	1 2 3 4	Sweeteners	1 2 3 4	Fresh Fish	1 2 3 4
Exercise	1 2 3 4				

b. How much water do you drink each day? \_\_\_\_\_ ounces  
What kind of water do you drink?

c. How much sleep do you get each night on the average? \_\_\_\_\_ hours  
Do you sleep well?

Do you wake up at night?

Do you wake up feeling refreshed or exhausted?

d. What is your energy level like?  
Excellent/Good/Fair/Poor

e. How many meals per day do you eat?  
Do you snack in between meals?

f. Do you have any digestion related concerns?



- d. What are your current health concerns?
- e. Do you have any known allergies or sensitivities?  
List all foods, medications, herbs, etc., to which you have a known allergy:
- f. Do you have any known auto-immune deficiencies?
- g. List and date any serious illness or surgeries you have had in the past.
- h. Are you under a medical doctor's care for your current condition? \_\_\_\_\_  
If so, what medications, drugs, or therapies are you currently using?  
List all medications you are currently taking (including aspirin, antacids, etc.)
- i. What medications, medical procedures, supplements, or therapies have you previously tried for your condition? Were any of these supplements or therapies helpful?
- j. What is your current state of emotions and well-being?  
Are you able to express your feelings and emotions?
- Have you experienced any trauma in the past 10 years? If so please list and date.

#### **IV. Interview Notes**

Additional Client Complaints:

Additional Observations:

Recommendations:

**V. Record of Additional Visits**

Client Name: \_\_\_\_\_

Date of Visit : \_\_\_\_\_

Status of Client Complaints:

New Observations

Revised Recommendations

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Date of Visit: \_\_\_\_\_

Status of Client Complaints

New Observations

Revised Recommendations