

Client Profile and Medical History
Health, Fitness and Nutrition Consultation

PERSONAL INFORMATION:

Name: _____ **Today's Date** _____

Address _____ **DOB** _____

City _____ **State** _____ **Zip** _____

Emergency Contact: Name _____ **Phone** _____

Home Phone _____ **Cell** _____

Email _____

Occupation _____ **Business Phone** _____

How would you rate your health? **Excellent** **Good** **Fair** **Poor**

How did you hear about our facility: _____

Reason for consultation: _____

Family Physician _____ **Last Visit** _____

Phone Number _____

Please indicate any personal history below.

Eyes

Eye disease or injury	Yes	No
Wear glasses or contacts	Yes	No
Blurred or double vision	Yes	No

Ears/Nose/Mouth/Throat

Hearing loss or ringing	Yes	No
Earaches or drainage	Yes	No
Chronic sinus problem or rhinitis	Yes	No
Nose bleeds	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Bad breath or bad taste	Yes	No
Sore throat or voice change	Yes	No
Swollen glands in neck	Yes	No

Cardiovascular

Heart Disease	Yes	No
Chest pain angina pectoris	Yes	No
Palpitation	Yes	No
Shortness of breath walking or Lying flat	Yes	No
Swelling of feet, ankles or hands	Yes	No
Hypertension	Yes	No

Respiratory

Wheezing	Yes	No
Chronic / Frequent Coughs	Yes	No
Spitting Up Blood	Yes	No
Asthma	Yes	No
Shortness of breath	Yes	No

Gastrointestinal

Loss of appetite	Yes	No
Change in bowel movements	Yes	No
Frequent Diarrhea	Yes	No
Rectal Bleeding or blood in stools	Yes	No
Nausea or vomiting	Yes	No
Painful bowel movements Or constipation	Yes	No

Genitourinary

Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Kidney stones	Yes	No
Female-pain with periods	Yes	No
Female-irregular periods	Yes	No

Musculoskeletal

Joint pain	Yes	No
Joint stiffness or swelling	Yes	No
Weakness of muscles or joints	Yes	No
Muscle pain or cramps	Yes	No
Back Pain	Yes	No
Cold extremities	Yes	No
Difficulty walking	Yes	No
Herniated Disc	Yes	No
Arthritis	Yes	No
Osteoporosis	Yes	No

Integumentary (skin, breast)

Rash or Open Sores	Yes	No
Change in skin color	Yes	No
Change in hair or nails	Yes	No
Varicose veins	Yes	No
Breast pain	Yes	No
Breast Lump	Yes	No
Breast Discharge	Yes	No
Implants	Yes	No

Neurological

Frequent Reoccurring Headaches	Yes	No
Lightheaded / Dizzy	Yes	No
Convulsions / Seizures	Yes	No
Numbness / Tingling	Yes	No

Tremors Yes No
Paralysis Yes No
Head Injury Yes No

Psychiatric

Insomnia Yes No
Memory Loss/Confusion Yes No
Nervousness Yes No
Depression Yes No
Anxiety Yes No

Endocrine

Glandular or hormone
problem Yes No
Excessive thirst or urination Yes No
Heat or cold intolerance Yes No
Skin becoming dryer Yes No
Change in hat or glove size Yes No

Hematological / Lymphatic

Slow to heal after cuts Yes No
Bleeding or bruising
Tendency Yes No
Anemia Yes No

Other:

Cancer Yes No
Type: _____
Herpes I or II Yes No
HIV Positive Yes No
Pregnant Yes No
Metal Plates or Implants Yes No
Organ Transplant Yes No
Pacemaker Yes No
Seizures Yes No
Shunts or Stints Yes No

Drug Allergies:

Known Food Allergies:

Environmental Allergies:

Surgeries or Injuries

Please indicate if you have ever had any of the following removed:

Tonsils Year _____ Adenoids Year _____

Appendix Year _____

List ALL dental surgeries and procedures; root canals and crown materials used;

1. _____ Year _____ 2. _____ Year _____

3. _____ Year _____ 4. _____ Year _____

Do you have any experience with the following: (please circle)
Homeopathy Electro Acupuncture

Bio-Feed Back Herbal Remedies

Others (please explain): _____

Do you regularly use or eat the following:
If so, how many times a week?

White sugar	Alcohol	Regular coffee	Decaf. Coffee
Tobacco	Soda	White Flour	Artificial Sweeteners

Additional Comments:

Family History:

Medications and/or Supplements:

Please circle yes or no for each question below:
Do you smoke? Yes or No
Do you exercise regularly? Yes or No
Do you wear contacts? Yes or No
Do you wear dentures? Yes or No
Do you wear hearing aids? Yes or No

Sharon Welch is a Health, Fitness and Nutrition Consultant. Sharon Welch is certified in Holistic Health Care, Holistic Nutrition, Life Coaching and Personal Training. I am not a licensed medical doctor. The evaluations performed are non-invasive traditional Oriental and European methods. These Evaluations are not considered a medical diagnosis.
Please indicate below that you have read and understand the above statement.

Signature _____ Date _____