Diane L. Rivers
Holistic Health Practitioner
(917) 648-1003
Diane@DianeRivers.com

HEALTH HISTORY

Please write or print clearly. All of your information will remain strictly confidential.

PERSONAL INFORMATION	
First name:	
Last name:	
E-mail:	
How often do you check e-mail?	
Home phone:	
Cell phone:	
Date of birth:	
Place of birth:	
Age:	
Height:	
Current weight:	
Weight 6 months ago:	
Weight 1 year ago:	
Would you like your weight to be different?	
If yes, how so?	

SOCIAL INFORMATION	
Relationship status	

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SOCIAL INFORMATION	
Where do you currently live?	
Children:	
Granchildren:	
Siblings:	
Pets:	
Occupation:	
How many hours do you work per week?	
Are family/friends supportive of your desire to make diet and/or life-style changes?	

HEALTH INFORMATION	
What are your main health concerns?	
Other concerns and/or goals?	
When in your life did you feel best?	
Any serious illnesses?	
Any serious injuries and/or surgeries?	
How is/was the health of your mother?	
How is/was the health of your father?	
What is your ancestry?	
What is your blood type?	
How is your sleep?	
How many hours do you sleep?	
Do you have problems falling asleep?	
Do you wake up at night?	

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HEALTH INFORMATION	
Why?	
Any pain?	
Any stiffness?	
Any swelling?	
Constipation?	
Diarrhea?	
Gas?	
Bloating?	
Do you have any allergies?	
Do you have any food sensitivities?	

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HEALTH NUMBERS	If you know, what is your most recent:
Vitamin D level	
TSH	
Free T3	
Free T4	
Reverse T3	
Magnesium level	
C-Reactive Protein	
Ferretin	
Total cholesterol	
HDL	
LDL	
Triglycerides	
Blood pressure	
Body mass index	
Waist circumference	
Fasting glucose or blood sugar	
Hemoglobin A1C	
Homocysteine	

Have you done gene testing?

_____

Have you done food sensitivity testing?

_____

ORAL HEALTH INFORMATION
Do you have or have you had any root canals, implants, mercury fillings, cavitations, gum issues or tooth decay? Please explain.

_____

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OTHER HEALTH INFORMATION
Please list your medications

Please list your supplements

Please list your current healers, doctors, therapies

What role do sports and exercise play in your life?

Other information you would like to share with me:

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FOOD INFORMATION

What did you eat growing up? Please fill out chart below.

Breakfast	Snack	Lunch	Snack	Dinner	Snack

What did you drink?

_____

_____

Did you drink liquids with your meals?

_____

_____

What do you eat today? Please fill out chart below.

_____

_____

What liquids do you drink?

_____

_____

Do you drink liquids with meals?

_____

_____

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Breakfast	Snack	Lunch	Snack	Dinner	Snack

Do you cook?

_____

What percentage of your food is home-cooked?

_____

Where do you get the rest from?

_____

Do you have any cravings?

_____

What kind of cravings (e.g., coffee, sugar, cigarettes, etc.)?

_____

Do you have any addictions?

_____

What do you believe is the most important thing you should change about your diet to improve your health?

_____

Anything else you would like me to know?

_____

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WOMEN ONLY
Are your periods regular?

_____

How many days is your flow?

_____

How frequent?

_____

Do you experience pain? Bad menstrual cramps? Please expain.

_____

Have you reached or are approaching menopause? Please explain.

_____

Birth control history:

_____

Have you or do you experience yeast infections or urinary tract infections? Please explain.

_____

OTHER INFORMATION
Do you have/what is your retirement plan?

_____

_____

[To be placed at the end of the form]

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