

# Natural Health Solutions

*A Family Wellness Center*

**Welcome To Our Clinic! Please Fill Out The Following Information Thoroughly So The Doctor Can Let You Know If You Are A Case We Can Accept. Please Feel Free To Ask Any Questions If You Need Assistance. We Look Forward To Serving You!**

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

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

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Birth Date: \_\_\_\_\_ Marital Status S M D W

How Were You Referred To This Office: \_\_\_\_\_

Are you in good health at the present time to the best of your knowledge? Yes No

Are you under a doctor's medical supervision at this time? Yes No  
If yes, for what? \_\_\_\_\_

Are you taking any medications at the present time? Yes No  
If yes, what medications? \_\_\_\_\_

History of high blood pressure? Yes No

History of diabetes? Yes No

History of frequent headaches or migraines? Yes No  
If yes, how often? \_\_\_\_\_ Medication? \_\_\_\_\_

History of constipation? Yes No

Serious injuries? Yes No  
Details: \_\_\_\_\_

Surgeries? Yes No  
Details: \_\_\_\_\_

Do weight problems run in your family? Yes No

If Yes, who? \_\_\_\_\_

Do you have a family history of:

- Diabetes? If Yes, who? \_\_\_\_\_
- Heart Disease? If Yes, who? \_\_\_\_\_
- Cancer? If Yes, who? \_\_\_\_\_
- Stroke? If Yes, who? \_\_\_\_\_

**Nutritional Evaluation:**

Present Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

When would you like to be at your desired weight?

Why do you want to lose weight? (Health Benefit? Appearance?) Please explain thoroughly:

\_\_\_\_\_

When did you begin gaining weight? \_\_\_\_\_

Reason why? \_\_\_\_\_

What has been your maximum weight (non-pregnant) and when? \_\_\_\_\_

Have you tried other weight loss program? Yes No

If yes, which ones? \_\_\_\_\_

Were you successful with it / were you able to keep the weight off? Yes No

Please explain: \_\_\_\_\_

Is your spouse, fiancée or partner overweight? Yes No

By how much is he/she overweight? \_\_\_\_\_

How often do you eat out? \_\_\_\_\_

What restaurants do you frequent? \_\_\_\_\_

How often do you eat "fast foods"? \_\_\_\_\_

Food allergies: \_\_\_\_\_

Food dislikes: \_\_\_\_\_

Food cravings: \_\_\_\_\_

Do you drink coffee or tea? Yes No If yes, how much daily? \_\_\_\_\_

Do you drink pop / soft drinks? Yes No If yes, how much daily? \_\_\_\_\_

Do you drink alcohol? Yes No  
What? \_\_\_\_\_ How much? \_\_\_\_\_ Weekly? \_\_\_\_\_

Do you use sugar substitutes? Yes No  
If yes, what? \_\_\_\_\_

What are your worst food habits? \_\_\_\_\_  
\_\_\_\_\_

Snack habits:  
What: \_\_\_\_\_  
How Much: \_\_\_\_\_  
When: \_\_\_\_\_

When there is increased stress in your life, do you tend to eat more? Yes No  
Explain: \_\_\_\_\_

Do you smoke? Yes No  
If yes, how much? \_\_\_\_\_

Typical Breakfast:  
What: \_\_\_\_\_  
When: \_\_\_\_\_

Typical Lunch:  
What: \_\_\_\_\_  
When: \_\_\_\_\_

Typical Dinner:  
What: \_\_\_\_\_  
When: \_\_\_\_\_

Describe your energy level? \_\_\_\_\_

- Activity level: (check one)
- Inactive
  - Light activity
  - Moderate activity
  - Heavy activity
  - Vigorous activity

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today? 1 2 3 4 5 6 7 8 9 10

\_\_\_\_\_  
Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_