HEALTH HISTORY

*This **confidential** questionnaire will help greatly in our study of your present health and will assist us in choosing an appropriate direction to take in working toward your optimum health. Please answer each of the following questions:*

Name: _____ Date:_____ Birthdate: _____
Mailing Address: _____Postal Code_____
E-Mail Addresses Home_____ Work/Other _____
Home Phone: _____ Business Phone: _____ Cell: _____
Your Occupation: _____ Height _____ Weight _____
Ethnic background _____ How did you hear about our services? _____

List one to five health complaints or goals you would like to attain for yourself, in order of priority:	How long have these been a concern for you?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Circle if you eat, drink or use:

alcohol	Desserts, pastry, chocolate	fast foods	Packaged foods
candy, refined sugar	fried foods	vegetable oil	Chewing gum
Brita Filtered Water	carbonated beverages	microwave	Aluminum pans
spring water	margarine	artificial sweeteners	luncheon meats
tap water			

How many cups do you drink, on average, per day?
coffee _____ non-herbal tea _____ herbal tea _____ water _____ milk (2%) _____ milk (skim) _____ milk (whole) _____
bottled/canned fruit juice _____ bottled/canned vegetable juice _____ soy/rice milk _____
soft drinks (diet) _____ soft drinks (reg.) _____ beer _____ wine _____ liquor _____

Do you wash your fruits and vegetables before consuming? _____

Do you smoke? Yes ___ No ___ if yes, how many cigars/cigarettes per day? _____
Have you ever smoked? _____ For how long? _____
Does anyone smoke in your household? _____ Your workplace? _____

Do you use any recreational drugs? Yes ___ No ___
If yes, please indicate what type and frequency of usage _____
Have you ever used recreational drugs? _____ For how long? _____
Have you ever been treated for drug dependence? _____
Do you get regular physical/medical checkups?_____ Do you have multiple sexual partners? _____

Do you have any Amalgam/Metal fillings in your teeth? _____ Root canals? _____
Please list any known Allergies _____
_____

How many hours of sleep do you get on average? _____ Do you awaken feeling rested? _____
How many hours do you work each day? _____ Do you enjoy your work? _____

How frequently do you eat in restaurants? _____ Travel abroad? _____
Do you have any pets and which kind? _____
Do you swim in lakes? _____ Swimming pools? _____ How often? _____

* **Women;**
* Have you ever been pregnant? _____ How many times? _____ How many children? _____
* Ever had breast augmentation surgery? _____When?_____
* Any breast tenderness? _____ Do you take hormone replacement therapy? _____
* Ever had an abortion or taken something to cause an abortion?_____
* Number of Days of blood on menstrual cycle_____ Is your menstrual cycle regular every 28 days?_____
* Do you take birth control pills?_____ How long?_____

What do you do for exercise? (please indicate type, how often you participate and for how long)

_____

_____

How many hours a day do you: Watch television? _____ Read? _____ Spend in front of a computer?_____
What are your main interests, hobbies and recreational activities?

_____

_____

Do you take vacations regularly? _____ Monthly, Annually…?_____
How long? _____ When was your last vacation? _____

Please circle level of stress you are experiencing right now:
minimal average considerable unbearable

What are the main stressors in your life?
financial job-related interpersonal health unfulfilled expectations
partner family members spiritual other

Do you participate in any spiritual discipline or belong to a church or religious group? _____
Are you an active participant? _____

Are you taking any ? **vitamins, minerals, herbal remedies, laxatives, prescription drugs/medicines, anti-biotics, penicillin**, **recent vaccinations**? etc. Please list & how long?

_____

_____

_____

Are you undergoing any treatment or therapy? Yes ___ No ___ If yes, please explain

_____

Health of relatives:
Father _____ Mother _____
Siblings _____
Family history hereditary diseases:
Who _____ What _____
_____ _____

Have you ever been hospitalized, injured, accidents?_____ When? _____
For what reason? _____

Any other health-related information you would like us to know about?

_____

_____

Please read carefully and sign:

I _____agree to release and discharge the nutritional practitioner, **Forever Healthy**, its employees and directors from any and all liabilities, claims, causes of action or damages of any kind whatsoever arising directly or indirectly or in any way related to the education received at **Forever Healthy**. A nutritional practitioner does not diagnose illness, disease or physical or mental disorder. A nutritional practitioner does not prescribe medical treatments or pharmaceuticals, nor perform any treatments. It has been made clear that nutritional therapy, advice is not a substitute for medical examination or diagnosis, and that it is recommended that I see a physician for any physical ailment that I may have. I agree that a nutritional practitioner is held harmless for any problems that might arise as a result of my therapy sessions. I agree that I have stated, to the best of my knowledge, all known medical and physical conditions, and agree to keep the practitioner updated on my physical condition.

Signature: _____ Signature of a parent if under 21 years old _____

Date: _____

Thank you for your co-operation! ***Please fill and fax to: 416-962-1445***

Forever Healthy 416-962-4400 Toronto, 866-962-4400 Toll Free