B3YOND NUTRITION LLC

2 Ardsley Road, Glen Ridge, NJ 07028 973.852.3335 beth@beyondnutrition-RDN.com

HEALTH HISTORY FORM

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

Date

PERSONAL INFORMATION

First Name:

Last Name:

Email:

Phone: Home

Work Mobile

Address

City/State/Zip

Birth Date

Height

Current weight:

Six months ago

One year ago

Would you like your weight to be different? ☐ Y ☐ N

If yes, how?

SOCIAL INFORMATION

Relationship status Children Pets Occupation Hours per week:

HEALTH INFORMATION

1. Please list your main health concerns

Other concerns and/or goals?

Was there a point in your life in which you felt you were at your healthiest? If so, when?

How is your sleep?

How many hours?

Do you wake up at night? ☐ Y ☐ N

Why?

Any pain, stiffness, or swelling? ☐ Y ☐ N

Constipation/Diarrhea/Gas? ☐ Y ☐ N

Allergies or sensitivities? ☐ Y ☐ N

If yes, please explain:

Ethnicity

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MEDICAL INFORMATION

Do you take any supplements or medications? Please list:

Do you participate in any additional therapies (chiropractic care, acupuncture, acupressure, healers?) Please list:

What role does exercise and/or sports play in your life?

FOOD INFORMATION

What foods did you eat often as a child? (Brief Examples)

Breakfast Lunch Dinner Snacks Liquids

What is your food intake like these days? (Brief Examples)

Breakfast Lunch Dinner Snacks Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? ☐ Y ☐ N

Do you cook? ☐ Y ☐ N

What percentage of your food is home-cooked? %

Where do you get the rest from?

Do you crave: ☐ sugar ☐ coffee ☐ cigarettes ☐ other

Any major addictions?

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

ADDITIONAL COMMENTS Anything else you would like to share?

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GENERAL HISTORY

Have you ever had?	Yes	No
1 Loss of Consciousness		
2. Frequent Headaches		
3. Dizziness or fainting spells		
4. Mental, brain, nervous trouble		
5. Fits, epilepsy, convulsions		
6. Lung disease or emphysema		
7. Asthma, hay fever, sinus		
8. Blindness, color blindness		
9. Ear trouble, decreased hearing		
10. Ringing in the ears		
11. Diabetes, frequent boils		
12. Tuberculosis, splitting of blood		
13. Shortness of breath		
14. Chest pains / discomfort		
15. Coughing or wheezing		
16. Heart trouble/heart attack/stroke		
17. High blood pressure		
18. Stomach trouble, ulcers		
19. Thinking or sleeping troubles		
20. Gall blader or liver disease		
21. Yellow jaundice or hepatitis		
22. Blood in stool or urine		
23. Change in bowel habits		
24. Skin disease or rash		
25. Kidney trouble/stones		
26. Rupture or hernia		
27. Varicose veins, leg ulcers		
28. Rheumatism, arthritis, gout		
29. Deformity, amputations		

Have you ever had?	Yes	No
28. Rheumatism, arthritis, gout		
29. Deformity, amputations		
30. Stiff joints, trick shouders/ knees		
31. Back trouble		
32. Scars, identifying marks		
33. Cancer or tumor		
34. Blood disease or anemia		
35. Military service		
36. Rejected for military service		
37. Eye trouble, vision problem(s)		
38. Unusual weight gain/loss		
39. Are glasses adequate?		
40. Ever x-rayed? When ___/___/___		
41. Seen a doctor in the last 2 years?		
42. Ever rejected for life insurance?		
43. Have you ever been rejected for employment for medical reasons?		
44. Serious infections		
45. Urine problem		
46. Thyroid, gland disease		
47. Any relative with (TB,diabetes,cancer)		
48. Ever seen a counselor, psychiatrist		
49. Tuberculin test		
50. Do you smoke?		
If yes, how much?		
51. Do you drink alcohol?		
If yes, how often?		
52. Are you unable to perform certain motions, assume positions or lift heavy objects?		

Remarks an any of the above answers:

Past Hospitalization or Surgery

Reason	Date

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Family History: Fill in completely for living and dead relatives

Relative	Age if living	Age at death	Cause of death if known	a*	Diabetes	Heart Attack	High Blood Pressure	Stroke	Kidney Disease	Tuberculosis	Cancer	Liver Disease	Epilepsy	Allergy	Asthma	Glaucoma	Psychiatric Illness	Alcoholism	Specify If Other
Maternal Grandmother																			
Maternal Grandfather																			
Paternal Grandmother																			
Paternal Grandfather																			
Father																			
Mother																			
Husband/Wife (Name)																			
Children (Names)																			