Life Style/History

Name:	Date:	
	Amount	**Frequency**
Cigarettes		
Caffeine		
Water		
Alcohol		
Food cravings: (i.e. sugar & sweets, chocolate, salty foods)		
Exercise		
If no, why not?		
Meditation/Yoga		
Stress management activities:		
Sleep		
Medications		
Vitamins / Supplements		

Family History

How many of your blood relatives (parents, grandparents, siblings, aunts, uncles, children) have had the following?

Please indicate with a check ✓ next to those that apply.

Asthma		**Drug addiction**	
Allergies		**Arthritis**	
Migraines		**Osteoporosis**	
Headaches		**Osteopenia**	
Diabetes		**Cancer**	
High blood pressure		**Kidney disease/ stones**	
High cholesterol levels		**Gallbladder disease or Gall stones**	
Stroke		**Thyroid disease**	
Depression		**Seizures**	
Eating disorder		**HIV/AIDS**	
Alcoholism			

Other:

Comments:

Personal Health History

Please indicate with a check ✓ next to those that apply.

Asthma		**Stroke**		**Cancer**		**Menopausal symptoms**	
Allergies		**Depression**		**Kidney disease/ stones**		**PMS**	
Sinus problems/ infections		**Eating disorder**		**Gallbladder disease or Gall stones**		**Autoimmune disorder:** *Please indicate which one(s) below:*	
Migraines		**Alcoholism**		**Thyroid disease**			
Headaches		**Drug addiction**		**Seizures**			
Diabetes		**Arthritis**		**HIV/AIDS**			
High blood pressure		**Osteoporosis**		**Hepatitis**			
High cholesterol levels		**Osteopenia**		**Neurological disease**			

Explanation/Comments:

Other Diagnosis:

Surgeries/Dates: