Simply Whole by Devi LLC
FUNCTIONAL MEDICINE HEALTH COACH NBC-HWC

Health History

Your Information:

Name: _____

Street Address: _____

City, State, & Zip: _____

Phone Number: _____

Email Address: _____

Age: _____

Gender: _____

Date of Birth: _____

Height: _____

Weight: _____

Tell me more about you:

Children: _____

Occupation: _____

Ideal Weight: _____

Weight One Year Ago: _____

Health Concerns:

What brought you to me?

Describe in detail your symptoms, and when did you first experience them?

Have you seen anyone else for these issues?

What other health practitioners are you seeing currently?

Are you taking any medications, supplements, vitamins, herbs, etc., currently? Please list them here.

Have you tried any other solutions to your issues, and have you had success in the past?

Have you had any surgical procedures in the past? Please describe.

Health History:

Have you travelled outside of the United States? When and where?

How often have you taken antibiotics? (As a child, teen, or adult.)

Have you experienced any major life changes or losses in life? Please describe.

Have any family members experienced any similar health issues as you are experiencing now?

How is the health of your parents? Grandparents + siblings?

Have you in the past or do you currently have any of the following health issues?

- ☐ Cancer
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Venereal Disease
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Chronic Yeast Infections
- ☐ Skin Issues

Lifestyle History:

Describe your family life:

Describe your physical activity level:

Types of activity you enjoy:

Do you vacation? How often?

How do you handle stress?

Do you use alcohol, drugs, medications, nicotine, or caffeine? Have you in the past?

Have you ever had periods of binge eating or hard dieting? Have you been on a diet for any length of time?

Have you ever been exposed to chemicals and toxins that you know of, and are you sensitive to odors? Do you have any mercury amalgam fillings?

How is your sleep? How many hours of sleep a night do you get on average?

For Women:

How are/were your periods?

Do you or did you have PMS? Please describe?

Do you have frequent yeast infections or UTIs?

Are you currently on birth control? Please describe.

Have you ever had problems getting pregnant?

Mental Health:

Do you suffer from depression or anxiety?

How is your energy overall?

Nutritional Health:

Do you have symptoms after eating, like bloating, pain, gas, brain fog, rashes?

Are there any foods that you know you are sensitive to? Or are there any foods that you avoid because they make you feel bad? Please describe.

Are there any foods that you crave? What kinds?

Describe your eating at the beginning of your health issues?

Are you currently on any special diet?

Do you eat out frequently, or do you cook your meals at home?

How are your bowel movements?

Miscellaneous Information:

At what point in your life did you feel best? Describe.

Do you have supportive friends and family? Who would be most supportive to you while making lifestyle changes?

What is the one thing you enjoy most about your life?

What are your goals and aspirations for our time together? & what is your why for these goals and aspirations?

What do you hope to get out of our work together?

If you could change one thing about yourself, what would it be?

What are any stumbling blocks that would prevent you from attaining your goals?

Is there any other information that you think would be helpful?