PERSONAL HEALTH EVALUATION

I. Personal Information

Name DOB Date

Address City State Zip

Phone Email Address Referred by

Occupation Sex Height Weight Blood Type

II. Diet, Nutrition and General Health Practices

A. How often do you consume the following?
(5 = Daily, 4 = 2-3 times/ wk., 3 = Weekly, 2= 2-3 times/ mo., 1 = Monthly, 0= Never)

☐	Refined Sugar	☐	Fried Foods	☐	Dairy Products	☐	Fish	☐	Green Salads
☐	White Flour	☐	Caffeine Drinks	☐	Pork/ Shellfish	☐	Whole Grains	☐	Vegetables
☐	Alcohol	☐	Artificial Sweeteners	☐	Red Meat	☐	Chicken/ Turkey	☐	Fresh Fruits

B. How much water do you drink each day? ounces

What kind of water do you drink?

C. How much sleep do you get each night on the average? hours

At what time do you go to bed on the average? Wake up?

Describe the quality of your sleep:

D. What is your energy level like? Describe:

E. How many meals/day do you eat?

F. How often do your bowels eliminate?

G. Do you feel like you are under stress? If so, explain.

H. What nutritional supplements are you currently taking?

Brand	Supplement	Dosage	# times per day

III. Medical Information

A. What are your current health concerns?

B. Check any issues for which you have received a medical diagnosis:

☐ Autoimmune ☐ Adrenals ☐ Pancreas/ Blood Sugar Issues ☐ Other:

C. List any serious illnesses or surgeries you have had in the past:

D. Are you under a medical doctor's care for your condition? ☐ Yes ☐ No

If so, what medications, drugs or therapies are you currently using?

Medication or Therapy	Dosage	# times per day

E. What medications, medical procedures, supplements or therapies have you previously tried for your condition(s)? Were any of these supplements or therapies helpful? If so, please note which ones were helpful.

Brand	Medication/ Supplement or Therapy Name	Dosage	# times per day

F. Were you breastfed as a baby? ☐ Yes ☐ No If yes, for how long? _____ If no, what kind of formula were you given? ☐ Soy ☐ Goat Milk ☐ Cow Milk ☐ Other: _____

What was your gestational age at delivery? _____

How were you delivered? ☐ Vagina ☐ C-Section Were there any complications during pregnancy or birth? If yes, please elaborate: _____

G. Additional comments or helpful information, if any.

IV. Interview Notes (for office use only)

Additional Client Complaints:

Additional Observations:

Tongue:

Color:

Coating:

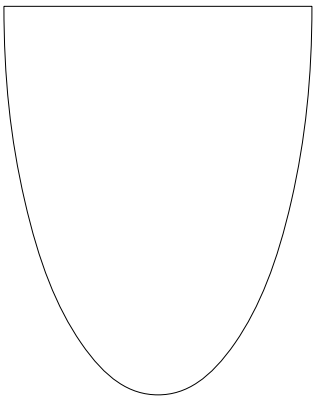
Movement:

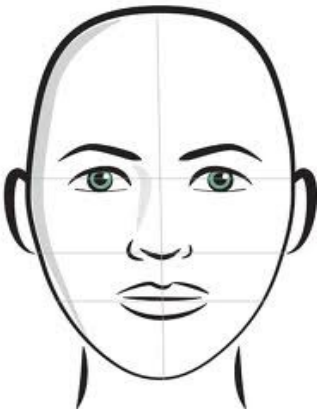
Markings:

Shape:

Underside:

Frenula:





Nails:

Color:

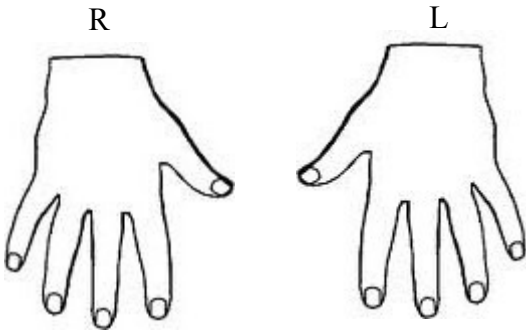
Markings:

Shape:

Strength:

Ridges:

Lunalae:



Eyes:

RIGHT:
Lacunae:

Psora:

ANW:

LEFT:
Lacunae:

Psora:

ANW:

Recommendations:

V. Record of Additional Visits

Date of Visit : _____

Status of Client Complaints:

Additional Observations:

Tongue:

Color:

Coating:

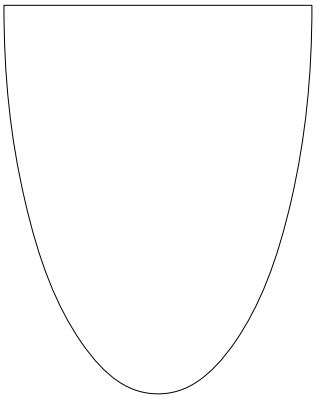
Movement:

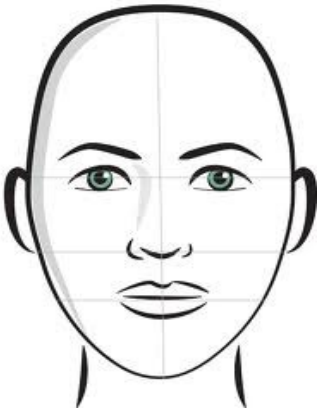
Markings:

Shape:

Underside:

Frenula:





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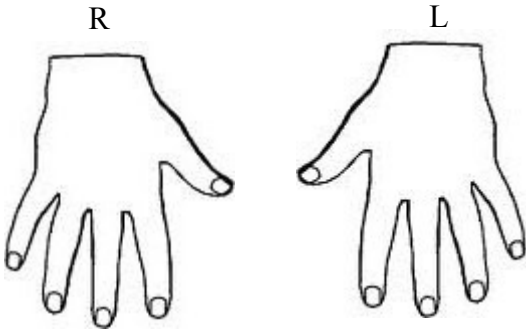

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LEFT:
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ANW:

Recommendations: