

Health History

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Mailing Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Height (ft): _____ Weight (lbs): _____ Weight 1 year ago: _____ Goal weight: _____

Marital Status: Single Partnered Married Separated Divorced Widowed

How did you hear about SHAPE Reclaimed? _____

How do you prefer to be contacted? Home Phone Cell Phone Text Email

QUESTIONNAIRE:

What are your three most important current health concerns?

1. _____
2. _____
3. _____

List any medical problems currently being managed by a physician: _____

List any surgeries with dates: _____

List allergies to any food, drugs or other known allergies: _____

List all supplements you are taking on a routine (daily - monthly) basis, include dose: _____

List all prescription and over-the-counter drugs you are taking on a routine (daily - monthly)

basis: _____

GENERAL LIFESTYLE:

What is your activity level on a scale from 1-10? (10 being very active) _____

What is your average energy level on a scale of 1-10 (10 being the optimal energy level you think you *should* have)? _____

Do you feel you get adequate sleep? Yes No _____

Do you wake rested? Yes No _____

Do you wake during the night? At what time? Yes No _____

Do you sleep next to any electronic devices? Yes No _____

Do you exercise? Yes No _____

Do you follow any particular diet? Yes No _____

Do you consume caffeine daily? Yes No _____

Do you use tobacco? Yes No _____

Do you consume alcohol? Yes No _____

Do you feel you've ever had a problem with overuse of drugs or alcohol? Yes No _____

Do you have a good support system? Yes No _____

Do you have a spiritual practice? Yes No _____

Have you tried SHAPE Reclaimed before? If so, when? _____

What was/wasn't successful? _____

What other programs have you tried? _____

What was/wasn't successful? How long did it take to gain the weight back? _____

What are the main stresses in your life? _____

Have you experienced any particularly life-changing stressful events? _____

What do you do to de-stress? _____

What are your some of your hobbies? _____

Why do you want to do SHAPE Reclaimed? You **MUST** have a non-weight related reason!

SYMPTOMS: Please check the boxes of symptoms that you are currently experiencing, or have experienced in the past 6 months:

Wood:

- | | | |
|--|--|--|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Gout | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Bursitis/Tendonitis | <input type="checkbox"/> Irritable/Angry | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Hepatitis/Liver disease | <input type="checkbox"/> Paralysis |

Fire:

- | | | |
|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hot/Cold intolerance | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Environmental sensitivities | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Varicose veins |

Earth:

- | | | |
|--|---|--|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Irritable when hungry |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Cold/Canker sores | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Tired after eating |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Excessive thirst/hunger | <input type="checkbox"/> Insulin resistance | <input type="checkbox"/> Worrisome |

Metal:

- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Rashes/Itchiness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Respiratory infections |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Despair/Apathy | <input type="checkbox"/> Hives | <input type="checkbox"/> Skin tags |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Wheezing/Hoarseness |

Water:

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Chronic urinary tract infections | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Incontinence | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Excess libido | <input type="checkbox"/> Infertility | <input type="checkbox"/> Prostate issues |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Ringing in ears |

Women:

- | | | |
|--|--|--|
| <input type="checkbox"/> Breast masses | <input type="checkbox"/> Lack of periods (premenopause) | <input type="checkbox"/> Menopause (age) _____ |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Painful/Heavy periods | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Spotting | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Pregnancies # _____ | <input type="checkbox"/> Miscarriage #/date _____ | <input type="checkbox"/> C-section # _____ |
| Are you/Do you plan to become pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Are you breastfeeding? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Are you taking birth control? What kind? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Are you on hormone replacement therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Other:

- | | | |
|--|---|--|
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Hernia | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> History of abuse | <input type="checkbox"/> Restless legs |
| <input type="checkbox"/> Employment difficulties | <input type="checkbox"/> History of antibiotic use | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> History of vaccine reactions | <input type="checkbox"/> Serious head injury |

Bowel Movements/day _____

Children (list age) # _____

Notes:

BLOOD WORK:

If you have recent blood work (within the last 6 months), please include a copy with this form. It is not required, but can be extremely helpful in understanding your full health picture.

SHAPE RECLAIMED INFORMED CONSENT:

I, _____, understand that SHAPE Reclaimed is a lifestyle modification, health transformation program designed to help me improve my overall health. This program is not intended to replace the guidance of my primary health care experts. While this program is not used to diagnose, treat, cure or prevent any disease, I understand any medications I am currently taking may need dosage adjustment. I agree to notify my prescribing physician that I am working with _____ and will be closely monitored while incorporating this program for embracing a healthier lifestyle. I understand an anti-inflammatory nutritional regimen will be recommended based on my unique health history, urinalysis, and symptoms.

Signature (patient/parent/guardian):

FINANCIAL AGREEMENT:

I, _____, agree to full financial responsibility for services rendered and products purchased. I understand that payment is required in full prior to service or purchase unless arrangements were agreed to in advance. Cash, check and PayPal are the only accepted forms of payment at this time. Notice of 24 hours is necessary for cancelled appointments. I may be charged a \$15 fee for a missed appointment.

Signature (patient/parent/guardian):
