OCWC Dietary and Lifestyle Counselling

Health History Assessment Form

Confidential Patient Information

Name: _____ Date: _____
Address: _____ City: _____ Province: _____ Zip Code: _____
E-mail: _____ Phone: _____
Occupation: _____ Height: _____ DOB: _____ Sex: M ◯ F ◯
Marital Status: Single ◯ Married ◯ Partner ◯ Separated ◯ Divorced ◯ Widow(er) ◯ Number of Children: _____
Who is your General Practitioner? _____ Phone: _____
Are you currently seeking other health practitioners such as a chiropractor, massage therapist, reflexologist, homeopath, naturopath, etc.? Yes ◯ No ◯ Please list: _____
How did you hear about my services? _____
Are you pregnant? _____
Hobbies: _____
Do you have a childhood history of infections? _____
Have you had recent antibiotic treatment? When and for what? _____
Have you ever had Candida (yeast infections)? Other fungal infections? _____
Do you have mercury amalgam fillings? How many? Have you had any dental problems?

_____
Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) and/or life threatening activities (e.g. firefighter, police officer, etc.)? _____
Is there anything you have experienced after which you could say your health has never been the same since?

_____
What types of therapies have you tried for these problem(s) or to improve your health overall? Select all that apply:
Diet modification ☐ Live Blood Analysis/Nutritional Counselling ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐
Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs ☐ Other: _____
Name all medications you are currently using (prescription and/or over-the-counter):

_____
_____
List all laboratory procedures performed (e.g. stool analysis, blood and urine chemistries, hair analysis):

_____
Outcome: _____
Select the level of stress you are experiencing on a scale of 1 to 10 (1 = lowest): 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯
How would consider yourself? Underweight ☐ Overweight ☐ Healthy weight ☐ Your weight today: _____ lbs
Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____
How many bowel movements do you have? _____ p/day _____ p/week
How would you describe your stools? Select all that apply:
Loose ☐ Watery ☐ Foul smelling ☐ Firm ☐ Heavy ☐ Hard ☐ Soft ☐ Well-shaped ☐ Floating ☐
Containing: Blood ☐ Mucus ☐ Visible food particles ☐ Colour: Brown ☐ Grey ☐ Pale ☐ Black ☐
Do you have any food, environmental or drug allergies? Also, list any foods you are sensitive to:

_____
_____
Are you preparing your own meals? _____
List the foods you love:

_____
_____
List the foods you crave:

_____
_____
List the foods you hate:

_____
_____
List the foods you eat on a daily basis:

_____
_____
List the foods you are avoiding for religious reasons:

_____
_____
How often do you eat in restaurants?

_____
_____

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addictions
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental Sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Uniary tract infection
- ☐ Varicose veins

Other_____

Medical (Men)

- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breast
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast Cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other_____

Date of last GYN exam_____

Mammogram +☐ -☐

PAP +☐ -☐

Form of birth control_____

# of children_____

# of pregnancies_____

☐ C-section_____

Age of first period_____

Date of last menstrual cycle

Length of cycle _____days

Interval of time between cycles ____

_____days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)_____

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorder (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide
- ☐ Other_____

Health Habits

- ☐ Tobacco
- ☐ Cigarettes: #/day_____
- ☐ Cigars: #/day_____
- ☐ Alcohol
- ☐ Wine: #glasses/d or wk_____
- ☐ Beer: #glasses/d or wk_____
- ☐ Caffeine:

Coffee # 6 oz cups/d_____

Tea: # 6 oz cups/day_____

Soda w/ caffeine: #cans/d_____

Other sources_____

- ☐ Water: #glasses/day_____

Exercise

- ○ 5-7 days/wk
- ○ 3-4 days/wk
- ○ 1-2 days/wk
- ○ 45 minutes or more duration /workout
- ○ 30-45 minutes duration /workout
- ○ Less that 30 minutes /workout
- ☐ Walk: #days/wk_____
- ☐ Run, jog, other aerobic: #days/wk_____
- ☐ Weight lift: #days/wk_____
- ☐ Stretch: #days/wk_____

Other_____

Nutrition and Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- ☐ Specific food restrictions:
  - ☐dairy ☐wheat ☐eggs
  - ☐soy ☐corn ☐all gluten
- ☐ Other_____

Food Frequency

Number of servings per day:

Fruits (citrus, melon, etc.)_____

Dark greens or deep yellow/orange vegetables_____

Grains (unprocessed)_____

Beans, peas, legumes_____

Dairy, eggs_____

Meat, poultry, fish_____

Eating Habits

- ☐ Skip meals (which ones)_____

_____

Number meals/day_____

- ☐ Graze (small, frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not.

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening primrose/GLA
- ☐ Calcium, source_____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals (describe)_____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ CoQ10
- ☐ Antioxidants (e.g. bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other_____

I Would Like to:

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, Ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body Composition

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress: Mental and Emotional

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment

- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

Average Diet Recall:

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Other:

***NOTE**: Please bring with you any other information or test results that may support this consultation.*
Thank you for taking the time to fill out your information to help me assist you best! Alicia Miller, CHNC