

Name:		Date:	
Address:		Unit:	
City:		State:	Zip:
PHONE	Home:	Mobile:	Work:
Email Address:			

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

Body Frame: Small Medium Large Blood Type if known: _____

Weight: Current: _____ Lowest: _____ Highest: _____ Ideal: _____

Status: Married Separated Divorced Widowed Single Partnership

Do you have any children? Yes No If so, how many? _____

Live with: Spouse Partner Parents Children Friends Alone

Occupation: _____ Hours per week: _____ Retired

Emergency contact: _____ Relationship: _____ Phone: _____

How did you hear about us?

Why would you like to coach with us?

What is your major complaint? Please List when each symptom began and be as descriptive as possible.

On a Scale of 0-100 (0 being absolutely horrific and 100 being AMAZING), rate the following:

Your Health: _____ Your Energy: _____ Your Emotional Health: _____

Your Diet: _____ Your Fitness: _____ Your Brain Health: _____

Your Relationships: _____ Your Finances: _____ Your Sleep: _____

During the past year, how many days did you miss work, or have your regular activities curtailed, due to illness? _____

In the past 12 months, how many days were you in the hospital? _____

Please list all medications you are currently taking INCLUDING the condition for which it is taken, dosage and frequency.

Medication	Condition	Dosage	Times per day

Please list all supplements you are currently taking INCLUDING the condition for which it is taken, dosage and frequency.

Supplement	Condition	Dosage	Times per day

Please describe any current or past usage of recreational drugs.

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.).

Is there anything else in your medical history that you consider to be relevant? (Even from childhood)

What is your employment history? Please provide brief summary including dates if possible.

Please list your past or present Hobbies that could be sources of toxicity or chemical exposure.

How often are you involved in these Hobbies currently?

Please list past or present allergies, including allergies to medications, food allergies, seasonal and environmental.

Please list all past surgeries and the condition each surgery was for, including dates.

Explain your sleep. (How many hours do you get, quality, how long does it take you to fall asleep, what is your typical bedtime and wake up time, do you feel rested when you wake up, do you dream?)

What type of health equipment have you purchased? (such as sauna, hyperbaric chamber, rife machine, etc.)

When was your last dental visit? _____ How often do you go in for cleanings? _____

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had your gallbladder removed? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have issues digesting Fats such as avocado, coconut oil, olive oil, cheese, etc? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you consume dairy? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have trouble with dairy? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you eat pork? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you eat gluten or wheat? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any trouble with gluten or wheat? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Did or do you drink diet soda? |

Is there a diet name or type of way you eat and how long have you been eating this way?

What are the foods you stay away from?

What are the foods you consume a lot of or often?

How many servings of alcohol do you consume in an average week? Note: a serving is defined as a 12-ounce beer, 5-ounce glass of wine, or 1.5 ounces of liquor.

- Yes No Do you currently use tobacco products?
 Yes No Have you previously used tobacco products?

General Questions

- Yes No Do you have a working carbon monoxide detector?
 Yes No Have you ever had your home tested for radon?
 Yes No Do you have high blood pressure issues?
 Yes No Do you have low blood pressure issues?
 Yes No Do you have sweaty or clammy hands?
 Yes No Do you have any swollen or tender lymph glands, tissue or skin areas?
 Yes No Have you ever had a blood transfusion? If so, when? _____
 Yes No Do you have a Smart Meter on your home?
 Yes No Have you ever had mono or suspected having mono?
 Yes No Do you have bad breath (no relief by brushing)?
 Yes No Do you have body odor (no relief by washing)?
 Yes No Do you need to drink caffeine to get going?
 Yes No Have you had weight loss of more than 10lbs in the last six months?
 Yes No Have you had weight gain of more than 10lbs in the last six months?
 Yes No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain. _____
 Yes No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, beauty salon, etc.)
 Yes No Do you have your house sprayed with pesticides for pest control?
 Yes No Do you spray herbicide (weed killers) in or around your home?
 Yes No Do you bug bomb your home?
 Yes No Do you use conventional insect repellants on yourself or family?
 Yes No Do you use perfume or cologne?
 Yes No Do you use aerosol hairspray?
 Yes No Do you get your nails done? If so, how often? _____
 Yes No Do you use air freshener in your house, work or car?

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your spouse or other family members work around chemicals? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Can you think of any other toxic exposures you may have had? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you handle receipt paper often? Such as a cashier. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your skin have a yellowish color? (such as hands) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you crave sugar or sweets? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you crave starches, grains, breads, carbs, etc.? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you crave salty foods? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does anyone in your family experience similar symptoms to yours? |
| | | What is your birth order (i.e. first born, second, third, etc.)? _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any history of kidney dysfunction? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you or any immediate family member have a history with cancer? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any history of heart disease, myocardial infarction (heart attack), etc.? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you currently having any thoughts of suicide? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been diagnosed with bipolar disorder, schizophrenia or depression? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have rapid mood swings? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you impatient, moody, nervous? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you in a constant state of anxiety or fear? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you excessively worry? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have difficulty making decisions? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have an inability to relax or restlessness? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of strokes? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been diagnosed with diabetes, thyroiditis, or heart disease? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever been in an auto accident, fallen or received a major physical injury? |

For Males Only

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have difficulty maintaining/attaining an erection? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does ejaculation cause pain? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is your sexual drive under active? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is your sexual drive overactive? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have issues with premature ejaculation? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have pain or coldness in genital area? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have infertility issues? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have discharge from penis? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a lack of early morning erections? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you presently or in the past have a rash on penis? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have swollen genitals? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have swelling in the groin? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have genital sores? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a lump or mass in scrotum? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have jock itch? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had a sexually transmitted disease? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you use any prescriptions for improving sexual function? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever used HCG, DHEA, or hGH? |

For Females Only

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are you in or did you go through perimenopause or menopause? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you get hot flashes/night sweats? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of missed periods? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have irregular periods? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have pelvic or vaginal soreness or pain? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have menstrual pain? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have heavy menstrual bleeding? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have infertility issues? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have an under active sex drive? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have an overactive sex drive? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have monthly weight gain? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you get bloating and swelling? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have tender breasts? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have vaginal itching? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have vaginal discharge or sores? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have vaginal dryness? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had a sexually transmitted disease? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you dislike intercourse? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have pain in ovaries? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you get water retention? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of miscarriages? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of ovarian cysts? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of uterine cysts or fibroids? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of endometriosis? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you had a hysterectomy? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever taken estrogen, progesterone, testosterone, DHEA, or hGH? |

Microbiome & Digestive Health

- Yes No Do you often have gas that has a sulfur or foul smell?
- Yes No Do you get heartburn or reflux?
- Yes No Are you sensitive to supplements?
- Yes No Have you ever been vegan or vegetarian for any length of time?
- Yes No Can you tolerate Meat?
- Yes No Do you have a history of using anti-acids, proton pump inhibitors or anything that blocks acid?
- Yes No Do you currently or have you used birth control?
- Yes No Do you currently or have you used hormone replacement therapy?
- Yes No If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
- Yes No Have you been on antibiotics in the last year? If so, how many rounds? _____
- Yes No Does your gut temporarily feel better after a round of antibiotics?
- Yes No Do you have a history of antibiotic use as a child or adult?
- Yes No Were you caesarian delivered (aka C-section)?
- Yes No Were you breast fed? If so, how long? _____
- Yes No Do you drink filtered water? If so, what type of filter do you have? _____
- Yes No Do you have a water filtration system for your entire house? If so, what type? _____
- Yes No Do you have a history of cold sores, warts or skin tags?
- Yes No Have you gotten food poisoning before?
- Yes No Do you skin issues?
- Yes No Do you have a history of athlete's foot or foot fungus such as on toenails?
- Yes No Do you have a history of jock itch or vaginal yeast infections?

How many times a day are you having a bowel movement? _____

Do your bowel movements have a tendency to be more: Harder (constipated) or Loose Stool (diarrhea)

Please explain your housing history (type of homes, where and when).
