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******Your personal information will remain strictly confidential******

Name: _____

Date: _____

E-mail Address: _____

Street Address: _____

City/State/Zip: _____

Home Phone _____ Cell Phone _____

Preference for communications from Beverly Seng: Home phone
Cell phone
Email

Date of Birth _____ Place of Birth _____

Age: Height Current Weight:

Would you like your weight to be different? If so, what?

Occupation: _____

How many hours do you work per week, inside or outside the home?

Relationship Status _____Children (?) _____

Blood Type (if known):

What are your three main health goals at this time?

1)

2)

3)

What are the main **health concerns** that trouble you the most at this time?

Do you have any other concerns or goals?

At what point in your life did you feel your best? _____

Will family and friends be supportive of your desire to make food and/or lifestyle changes at this time? _____

Are you currently under a practitioner's care for a specific health issue or issues? If so, what issue(s)?

Are you taking **prescription medications** (including hormones and chemotherapy) for this condition(s)? If so, please list medication, dosage, purpose of medication, and whether it is helping you.

Have you taken **prescription medications**, including hormones and chemotherapy, in the **past**? If so, please list medication, dosage, purpose of medication, and whether it helped you.

Please list any **surgeries, accidents, injuries or childhood diseases** you have had along with the type and date:

Please indicate any **current or prior antibiotic use**, listing when, what antibiotic, and for what purpose.

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, over-the-counter medications, aspirin, laxatives, diet pills, athletic performance supplements, or any other supplements? Please list all below including name brands and amounts that you take. (Attach separate sheet if necessary)

Lifestyle

Exposures: do you use any of the following?

Alcohol None 2 or less drinks /day >2/day or stopped recently

If stopped recently, when was that? _____

Coffee None 2 or less drinks /day >2/day or stopped recently

If stopped recently, when was that? _____

Diet soda None 2 or less drinks /day >2/day or stopped recently

If stopped recently, when was that? _____

Regular soda None 2 or less drinks /day >2/day or stopped recently

If stopped recently, when was that? _____

Other Caffeinated drinks None 2 or less drinks /day >2/day or stopped

If yes, what do you drink? _____

Cigarettes/cigars/nicotine gum Yes No or stopped recently

Amount _____

If stopped recently, when was that? _____

What was prior amount? _____

Are you exposed to secondhand smoke? Yes No

At Home?
Outside the home? Please specify.

Do you have amalgam ("silver") fillings? Yes No

If yes, how many? _____

Lifestyle: Healthful Habits

Do you have any hobbies? Yes No

If so, what?

Have you been travelling recently? Yes No

If so, where?

Do you exercise regularly? Yes No

If yes, please describe.
If no, please explain.

Brush and Floss? Yes No

Lifestyle: Sleep Habits

How well do you sleep?

Well Trouble falling asleep Trouble staying asleep Insomnia

If you wake up, in the night, how often?_____

At what time(s)? _____

What time do you go to bed? _____

What time do you wake up? _____

How many hours do you sleep, on average? _____

Do you feel rested when you wake up? Yes No

If no, how long has this been happening? _____

Is the room completely dark at night? (Nightlight, street lamp, TV, clock, etc.) Yes No

Lifestyle: Eating Habits

How many glasses of water do you drink per day? ___What water source? _____

What were your eating habits like as a child? (List types of foods you ate)

Breakfast Lunch Dinner Snacks Beverages

What do you often eat these days?

Breakfast Lunch Dinner Snacks Beverages

Do you have any known allergies or sensitivities to foods, medications, or herbs? Please list all.

How often do you eat out?

Do you cook?

Where do you get most of your food?

What are the three healthiest foods you eat each week?

Do you crave **sugar**? Yes No

Do you crave **salt**? Yes No

Are there any other foods that you crave? Yes No

If yes, please list.

Do you ever feel tired, bloated, and/or gassy after meals? Yes No

Do you experience constipation or diarrhea? Yes No
If yes, when and how often?

Do you experience heartburn indigestion bloating flatulence? (Please circle)

Do you ever feel excessively hungry? Yes No

Do you ever have an energy crash? Yes No

If yes, please explain the circumstances and how often.

Do you have a poor appetite? Yes No

Were you breast-fed as a baby? Yes No
If yes, for how long were you breastfed? _____

Are you satisfied with your eating habits? Yes No

Family Health History

Diabetes		Kidney disease
Heart Disease		Arthritis
Asthma		Gallbladder disease
Cancer		Type of cancer?
Depression ADHD symptoms		
Mother	Age:	Cause of death
Father	Age:	Cause of death
Maternal Grandmother	Age:	Cause of death
Paternal Grandmother	Age:	Cause of death
Maternal Grandfather	Age:	Cause of death
Paternal Grandfather	Age:	Cause of death

Describe the health of your mother.

Describe the health of your father.

Personal Health History: Please circle any symptoms that you currently experience.

General Symptoms:	Ears:	Eyes:
Allergies - Colds- Depression - Fatigue - Fainting spells - Frequent illness –	Itchy ears - Earaches - Ear Infections - Ringing in Ears - Ear Drainage - Hearing Loss -	Watery Eyes - Itchy or red eyes - Blurred Vision - Tunnel Vision -
Nose:	Mouth/Throat:	Head:
Stuffy nose - Sinus problems or infections- Hay Fever - Sneezing - Excess Mucus - Nose Bleeds -	Chronic Sore throat - Swollen gums – Bleeding gums Canker sores - Sensitive teeth-nerves Cavities	Dizziness - Headaches -
Joint/Muscle: Joint pain - Arthritis - Muscle pain - Varicose veins - Back pain – Bursitis- Sciatica Plantar fasciitis	Endocrine system Hypoglycemia Thyroid problems Diabetes	Lungs/Respiratory: Chest congestion - Asthma - Shortness of breath - Bronchitis - Chronic Cough – Pneumonia
Skin: Acne - Boils - Hives or rashes - Hair loss - Excess sweating - Dryness - Eczema Psoriasis - Sensitive skin - Bruising easily – Skin cracks easily-	Heart/Cardiovascular: Irregular heartbeat - Rapid heartbeat - Chest pains - Swelling of ankles - Numbness, tingling in extremities High/Low blood pressure – Sense of pressure in chest Sense of doom in chest Heart attack Diagnosis of congestive heart failure or cardiomyopathy	Urinary Tract Bladder trouble - Kidney failure - Kidney infection - Kidney stones - Prostate trouble - Chronic UTI - Burning urination -

ACKNOWLEDGEMENT

I acknowledge that Beverly Seng does not claim to be a doctor or a dietician or a nutritionist, as defined by Virginia state law, and that Beverly Seng does not claim to diagnose or treat any conditions.
I acknowledge that if I experience any changes in my health or in my current medications, I will immediately communicate this information to Beverly Seng.

Client Signature_____

Date_____