CHERYL M

HEALTH MUSE

INSPIRATION FOR A HEALTHIER LIFE

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Please type or print clearly. All of your information will remain confidential between you and the Health Muse

PERSONAL INFORMATION

First name: _____ Last name: _____

Email address: _____ How often do you check your email?: _____

Phone: _____ Cell phone: _____ Work phone: _____

Age: _____ Height: _____ Birthdate: _____ Place of birth: _____

Current weight?: _____ Weight 6 months ago: _____ 1 year ago: _____

Would you like your weight to be different? _____ What would that weight be? _____

SOCIAL INFORMATION

Relationship status: _____

Where do your currently live? _____ How long? _____

Children: _____ Ages: _____ Pets: _____

Occupation: _____ Hours per week: _____

Other activities(church, volunteer work, clubs, Children's events): _____

Hours per week: _____

Support system(friends, family, church): _____

Has there been any major change in your family in the last year?

Have you experiences any major losses in life?

How much time have you had to take off from work/ school in the last year:

HEALTH INFORMATION

How is your general health?

List your main health concerns

Of the health concerns listed above, where would you like to start?

1.
2
3

Other concerns and/or goals?

Any serious illnesses/hospitalizations/injuries?

How often did you take antibiotics as a child?

How often did you take antibiotics as a teen?

How often have you taken antibiotics as an adult?

At what point in your life did you feel best?

How is/was the health of your mother?

How is/was the health of your father? _____

What is your ancestry? _____ What it your blood type? _____

How is your sleep? _____ How many hours? _____ How long to fall asleep? _____

Do you wake up in the middle of the night? _____ Why? _____

How long to get back to sleep? _____

Any pain, stiffness, or swelling? _____ Where? _____

Poop, How often a day? _____ Constipation/Diarrhea/Gas? _____

Any stomach upset? _____ When? _____

Allergies or sensitivities? Please explain: _____

_____

_____

_____

Were you natural birth or C Section: _____

Were you breast fed: _____

MEDICAL INFORMATION:

Do you take any supplements or medications? Please list: _____

_____

_____

_____

Any healers, helpers, or therapies with which you are involved? Please list: _____

_____

What role does sports and exercise play in your life? _____

_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

How many servings of fruit and veggies as a child daily? _____

What kind of veggies? Fresh. Frozen, canned _____

What kinds of fruits? Fresh, Frozen, Canned _____

Did you eat meat/fish/chicken? What kind? _____

Are there any foods that you avoided as a child because of how they made you feel? _____

_____

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

How many servings of fruit and veggies daily? _____

What kind of veggies? Fresh, Frozen, Canned _____

What kind of Fruits? Fresh, Frozen, Canned _____

Did you eat meat/fish/chicken? What kind? _____

How much water do you drink a day? _____

Are there any foods that you avoid now because of how they make you feel? _____

_____

Do you eat any foods where you get immediate bloating? gas? Sneezing? Hives? _____

Identify foods and reaction _____

Do you get fatigue? Muscle aches? Sinus congestion? from eating any foods? _____

Identify foods and reaction _____

Any foods that you crave? _____

Which of these foods do you consume?

Soda _____ If so, how often? _____ Dairy _____

Diet soda _____ If so, how often? _____ Gluten(wheat, barley, rye) _____

Refined sugar _____ If so, how often, how much? _____ Coffee _____

Alcohol _____ If so, how often, how much? _____

Fast food _____ If so, how often? _____

Are you currently on any special diet? (Paleo, Vegan, Vegetarian, Diabetic, Dairy free, Blood Type, Raw, Refined sugar free, gluten free) _____

Anything else I should know about your current diet, history, or relationship to food? _____

_____

Do you cook? _____ What% of your food is home cooked? _____

Do you like to cook? _____ Why? _____

Where do you get the rest of your food? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

_____

The most important thing I should change about my diet to improve my health is: _____

_____

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

_____

Who in your life will be the most supportive? _____

Who in your life will be the least supportive? _____

Have you used or abused alcohol, drugs, meds, tobacco, or caffeine? Do you still? _____

How well do you handle stress? _____

What do you do to relax? (reading, bubble baths, massage, facials, walking, Meditation, Breathing exercises) _____

MENTAL HEALTH

How are your moods in general? Do you experience anxiety? Depression? Anger? Please list by type and how often _____

On a scale of 1-10 what is your energy like (1 being worst, 10 being best) _____

Do you get brain fog? _____

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

FOR WOMEN ONLY

How are your menses? PMS? Painful periods? How regular? _____

In the second ½ of your period, do you still experience breast tenderness, water retention, irritability? _____

Any yeast infections? Urinary tract infections? How often? _____

Birth control pills? Length of time on them? _____

Any problem with conception/pregnancy? _____

Ever had hormone replacement therapy or hormonal supportive herbs? If so, list here: _____

SEXUAL HISTORY

Any concerns or issues with your sexual functioning that you would like to share with me? (pain with intercourse, dryness, libido issues, erectile dysfunction?) _____

Anything else about your sexual history that you would like to share? _____

ADDITIONAL COMMENTS

What are your health goals and aspirations? _____

Anything else you would like to share? _____

_____

_____