Total Health Resonance
Health History/Intake Form

Date:_____

Last name:_____ First:_____ Sex: ☐ M ☐ F

Address:_____City:_____State:_____Zip Code:_____

Email Address:_____ Phone #: ( )_____

Age:_____ Birthdate:_____ Place of Birth:_____

☐Married ☐Divorced ☐Single ☐In a Relationship, Other:_____

Children: ☐ No ☐ Yes: How many?_____ Ages of Children:_____

Occupation:_____Employer:_____Hrs. per week:_____

In case of emergency, contact:_____

Relationship:_____ Phone:_____

Height:_____ft. _____in. Weight:_____lbs. Weight 1 year ago:_____

Allergies to food, drugs, chemicals (list):_____

Main health concerns 1._____
in order of importance:
2._____

3._____

Current Medications: (prescription and over the counter)
_____

_____

Current Supplements:

☐Multi-vitamin/mineral	☐Protein Shakes	☐Minerals (Calcium, Magnesium,
☐Fish oil (omega 3 fatty acids)	☐Herbs	Zinc, Selenium, Copper)
☐Probiotics	☐Amino Acids	☐Other: _____
☐Digestive Enzymes	☐CoQ10	_____
☐Anti-oxidants	☐Vitamins (A, D, C, D, E, K)	_____

Medical History:

☐Arthritis	☐Diabetes	☐Liver/Gall Bladder Disease
☐Asthma	☐Fibromyalgia	☐Migraine Headaches
☐Alcoholism	☐GERD (reflux)	☐Neurological Problems
☐Autoimmune Disease	☐Heart Disease	☐Osteoporosis
☐Cancer:_____	☐High Blood Pressure	☐ Thyroid Problems
☐Cholesterol, elevated	☐Irritable Bowel Syndrome	☐ Skin Problems
☐Depression	☐Kidney/Bladder Disease	☐ Stroke/Vascular Disease

☐Other:_____

How often have you taken antibiotics:
As a *child*: ☐Less than 5 times ☐More than 5 times and as an *adult*: ☐Less than 5 times ☐ More than 5 times

Men:
☐Benign Prostatic Hyperplasia ☐Infertility ☐Prostate Cancer

Women:
☐Menstrual Irregularities ☐Endometriosis ☐Infertility ☐Fibrocystic Breasts ☐PMS
☐Pelvic Inflammatory Disease ☐PCOS ☐Fibroids/ovarian cysts
☐Pregnant: Due Date:_____ ☐Peri-menopause ☐Menopause
Age menstruation began:_____

Family History: (also indicate which relative – mother, father, grandparent, sibling, child, etc.)
Diabetes: ☐No ☐Yes: _____
Heart Disease: ☐No ☐Yes:_____
High Blood Pressure: ☐No☐Yes:_____
Skin Disorders: ☐No☐Yes:_____
Arthritis:☐No☐Yes:_____
Breast Cancer:☐No☐Yes:_____
Uterine/Ovarian Cancer:☐No☐Yes:_____
Prostate Cancer:☐No☐Yes:_____
Colon Cancer:☐No☐Yes:_____
Alzheimer's:☐No☐Yes:_____
Other:_____

List Major Surgeries/Injuries:
_____ Year:_____

_____Year:_____

_____Year:_____

Social History:
1. Who do you live with? (include children, parents, relatives, friends, etc.):
_____

_____
2. Do you have pets?☐No☐Yes: list:_____
3. Have you travelled outside of the US: ☐No☐Yes: Where:_____
4. Use of alcohol (beer, wine, liquor):☐No☐Yes: How often/how much:_____
5. *Current* use of tobacco (cigarettes, cigar, pipe): ☐No☐Yes;
   How often:_____, How many a day:_____How many years total:_____
6. Use of recreational drugs: ☐No☐Yes: Describe:_____

Lifestyle Assessment
A. **Chemical/Toxin/Heavy Metal Exposure**
1. Have you sprayed chemicals for weed and/or pest control? ☐No☐Yes: Describe:_____
   _____
2. Have you ever worked as a painter or in a manufacturing/chemical/pesticide factory?
   ☐No☐Yes: Describe:_____
   a. Any unusual incidents with chemical exposure? ☐No☐Yes: Describe:_____
   _____
3. List chemicals you have been exposed to since childhood:_____
   _____

4. Have you ever lived near a battery manufacturing plant or any other chemical factories: ☐No☐Yes: Describe:__
_____
5. Have you had exposure to mercury (such as a broken thermometer)?☐No☐Yes: Age:_____
6. Do you presently have mercury (silver) fillings? ☐No☐Yes: How many?_____
Did you ever have mercury fillings? ☐No☐Yes: When were they removed:_____
Do you have crowns?☐No☐Yes: How many?_____ Root canals?☐No☐Yes: How many?_____
7. Have any of your homes contain lead paint or pipes?☐No☐Yes: Age of exposure:_____
8. List brand name of products you use on you scalp and skin, i.e. lotions, shampoos, make-up, shaving creams etc
_____
_____
9. Do you have your clothes dry cleaned on a regular basis? ☐No☐Yes; Describe:_____
10. Is your furniture/upholstery/carpet treated with chemicals (fire retardant, water proofing, etc.) ☐No☐Yes:
Describe:_____
11 Do you have artificial joints, implants (including tooth)? ☐No☐Yes: Describe:_____
12 Do you drink most of your water from ☐tap, ☐plastic bottles, ☐filtered water, type:_____
13 Do you have a shower filter for chlorine removal: ☐No☐Yes
a. How often do you swim or take baths in chlorinated water?_____
14. Have you seen any black mold on your windowsills or basement? ☐No☐Yes: Describe:_____
_____

B. **Electromagnetic Pollution:**

1. Do you live within ¼ mile of high voltage power lines or cellular towers?☐No☐Yes: For how long?_____
2. How many hours *a day* do you use a cell phone?_____ hours
I use my cell phone mostly by:☐holding phone directly to my ear
☐speaker
☐bluetooth headset
3. How many hours a day do you use a computer?_____hours, ☐desktop or ☐laptop
If laptop, do you set it on your body while using internet? ☐No☐Yes
4. How many hours a day do you watch TV?_____hours
5. Indicate which device you use before or while in bed: ☐TV, ☐computer/internet, ☐cell phone
☐iPad or other mobile device
6. Do you use an electric blanket? ☐No☐Yes
7. Check any item that is in use that is located within 2 feet of your bed:
☐computer, ☐alarm clock, ☐phone, ☐TV, ☐Stereo, ☐humidifier/dehumidifier, ☐other:_____
a. Check any major appliances located directly below or on the other side of the wall where your bed is located:
☐refrigerator, ☐hot water heater, ☐stove/microwave, ☐breaker box, ☐other:_____

C. Sleep

1. On average, how many hours of sleep per night do you get?_____
2. Average bedtime:_____ Average waking time:_____
3. Do you have trouble falling asleep? ☐No☐Yes
4. How often do you wake up at night?_____
5. Do you feel rested and refreshed when you wake up? ☐No☐Yes
6. Rate your quality of sleep on a scale of 1-10 (1=don't sleep, 10=sleep soundly all night) _____
7. What have you done to improve your sleep?_____
_____

D. Stress

1. Rate your *current* level of stress on a scale of 1-10 (1=lowest, 10=highest):_____
2. What are the major causes of your stressors?
   a. _____
   b._____
   c._____
3. Describe how well you are currently handling your stress?_____
_____
4. Describe hobbies, interests, passions in your life:_____
_____
5. How would you describe your current emotional health:_____
6. Do you have a good support system ☐No☐Yes: Describe:_____
_____
7. What do you do to help deal with your stress level?_____
_____

D. Exercise and Weight Management

1. Describe what you do for exercise:(check all that apply) ☐Aerobics (running, biking, elliptical) ☐Interval/Burst Training, ☐Strength Training, ☐Yoga/Pilates, ☐Stretching, ☐Other_____
2. How often do you exercise?_____
3. What limits you from exercising? ☐No time, ☐No energy, ☐No desire, ☐Pain/injury, ☐Other_____
4. Are you satisfied with your current weight? ☐Yes☐No: Describe:_____
   a. What is your goal weight?_____

E. Nutrition

1. Are you following a specific nutritional program? ☐No ☐Yes Check all that apply:
☐Dairy free ☐Gluten free ☐Grain free ☐Vegetarian ☐Vegan ☐Diabetic
☐Yeast free ☐Low Glycemic ☐Anti-inflammatory ☐Other:_____
2. List other foods you avoid, i.e. soy, eggs, corn, peanuts, sugar, processed foods, etc._____
_____
3. Do you have symptoms such as belching bloating gas, hives, etc. immediately after eating:
☐No ☐Yes: Explain_____
4. List known food sensitivities:_____
_____
5. How many servings do you have of each food type? *Circle per day or per week*.
☐Vegetables(dark green/deep yellow, orange-exclude potatoes):_____per day or week
☐Fruit:_____per day or week ☐Dairy:_____per day or week
Grains/Bread:_____per day or week ☐Beans, peas, legumes:_____per day or week
☐Meat, Poultry:_____per day or week ☐Fish, seafood: _____per day or week
☐Healthy Fats (coconut oil, olive oil, nuts and seeds, etc):_____per day or week
☐Eggs:_____per day or week ☐Sweets (cookies, cake, ice cream, etc.):_____per day or week
☐Processed foods (crackers, packaged manufactured foods,):_____per day or week
6. What percentage of your diet is organic foods_____% What type of foods:_____

7. On a typical day, what do you drink?

TYPE	HOW MUCH
☐Soda	_____
☐Fruit Juice	_____
☐Alcohol	_____
☐Coffee/Tea (caffeinated)	_____
☐Herbal Tea	_____
☐Decaf Coffee	_____
☐Energy/Sports Drinks	_____
☐Filtered Water	_____
☐Tap Water	_____
☐Other	_____

8. Eating Habits: (Check all that apply)

I eat: ☐1meal per day ☐2 meals per day ☐3 meals per day ☐graze – small frequent meals
☐1-3 snacks/day ☐eat constantly whether hungry or not ☐skip meals-which one:_____

9. How often do you eat out?_____ times per week. Fast food restaurants? ☐No ☐Yes

10. Do you have food cravings?☐No ☐Yes If so, what do crave?_____
_____

Briefly describe what your typical food intake is for one day (include beverages)?

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

How many ounces of water do you drink daily? _____ ounces

G. Commitment:

1. How committed are you to making positive lifestyle changes on a scale of 1-10 (1=not committed, 10=extremely committed)?_____

2. What is standing in your way?_____
_____

3. Will family and friends be supportive of your desire to make food and lifestyle changes?
☐ Yes, ☐No: Explain:_____

4. Anything else you want to share?_____
_____
_____