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? _____

☐ Yes	☐ No	Have you had you gallbladder removed?
☐ Yes	☐ No	Do you have issues digesting Fats such as avocado, coconut oil, olive oil, cheese, etc?
☐ Yes	☐ No	Do you consume dairy?
☐ Yes	☐ No	Do you have trouble with dairy?
☐ Yes	☐ No	Do you eat pork?
☐ Yes	☐ No	Do you eat gluten or wheat?
☐ Yes	☐ No	Do you have any trouble with gluten or wheat?
☐ Yes	☐ 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 caffiene 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?

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

For Males Only

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

For Females Only

☐ Yes	☐ No	Are you in or did you go through perimenopause or menopause?
☐ Yes	☐ No	Do you get hot flashes/night sweats?
☐ Yes	☐ No	Do you have a history of missed periods?
☐ Yes	☐ No	Do you have irregular periods?
☐ Yes	☐ No	Do you have pelvic or vaginal soreness or pain?
☐ Yes	☐ No	Do you have menstrual pain?
☐ Yes	☐ No	Do you have heavy menstrual bleeding?
☐ Yes	☐ No	Do you have inferitility issues?
☐ Yes	☐ No	Do you have an under active sex drive?
☐ Yes	☐ No	Do you have an overactive sex drive?
☐ Yes	☐ No	Do you have monthly weight gain?
☐ Yes	☐ No	Do you get bloating and swelling?
☐ Yes	☐ No	Do you have tender breasts?
☐ Yes	☐ No	Do you have vaginal itching?
☐ Yes	☐ No	Do you have vaginal discharge or sores?
☐ Yes	☐ No	Do you have vaginal dryness?
☐ Yes	☐ No	Have you ever had a sexually transmitted disease?
☐ Yes	☐ No	Do you dislike intercourse?
☐ Yes	☐ No	Do you have pain in ovaries?
☐ Yes	☐ No	Do you get water retention?
☐ Yes	☐ No	Do you have a history of miscarriages?
☐ Yes	☐ No	Do you have a history of ovarian cysts?
☐ Yes	☐ No	Do you have a history of uterine cysts or fibroids?
☐ Yes	☐ No	Do you have a history of endometriosis?
☐ Yes	☐ No	Have you had a hysterectomy?
☐ Yes	☐ 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).

_____
_____
_____
_____
_____
_____