

HISTORY FORM

Name: _____	M / F _____	Date: _____
Address: _____	City / State: _____	Zip Code: _____
Phone #: _____	Cell Phone #: _____	E-mail: _____
Primary Doctor: _____	Emergency Contact / Phone: _____	
SS #: _____	Date of Birth _____	Age _____
How did you hear about us? _____		
If referred, by whom? _____		
<u>If you are using insurance:</u>		
Insured Name (if different than above): _____	Insured SS#: _____	
Insured DOB: _____	Insured Address: _____	
Insured Employer: _____	Work Phone: _____	Home Phone: _____
Height: _____	Weight: _____	
Marital Status: M S D W	# of children: _____	
Occupation: _____	Employer: _____	Work phone: _____
Are you on a particular diet? Y N	If so, please give a brief description: _____	

Has this diet helped you with your goals? _____		
Do you have any allergies? Y N	Please list any known allergies / sensitivities to foods, medications, etc : _____	

How many glasses of water do you drink per day? _____	Coffee? _____	Tea? _____ Soda / Juice? _____
Average number of alcoholic drinks per week: _____ Mostly what? _____		
Do you smoke? Y N	cigarettes cigars pipe	How many per day? _____ or per week? _____
Do you sleep soundly at night? Y N	If not, please explain: _____	
Average number of hours you sleep: _____ How often do you wake up at night? _____		
Have you noticed there is a particular hour of the night that you wake up? _____		
Do you have trouble falling asleep? Y N		
Do you exercise? Y N How often? _____		
What type of exercise do you do mostly? (aerobics, weight training, swimming, etc.) _____		
How often do you have a bowel movement? _____ / Day OR _____ / Week		
Are you taking any painkillers, such as Aspirin or Tylenol? _____ / Day OR _____ / Week		
Do you seem to get sick a lot or take antibiotics more than once every couple or years? Y N		
If known, what is your cholesterol level? _____ Last checked? _____		