

## CLIENT HEALTH HISTORY

*All information remains confidential*

*Please fill out this document and submit, or print & fax to 604.925.0322*

Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_

Male  Female

Family Physician

\_\_\_\_\_

Occupation

\_\_\_\_\_

Are you taking any medications? Please list:

\_\_\_\_\_

Do you use over the counter medications? Please list:

\_\_\_\_\_

Do you have any known food, environmental, animal or drug allergies? Please list:

\_\_\_\_\_

Are you taking any vitamins or other food supplements? Please list:

\_\_\_\_\_

Please list any illnesses with which you have been diagnosed:

\_\_\_\_\_

Do you exercise? Explain:

\_\_\_\_\_

What are your main health concerns?

\_\_\_\_\_

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Are you currently seeing other health practitioners such as chiropractor, massage therapy, reflexology, homeopath, naturopath etc?

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Have you had any surgeries? What and when:

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Have you had any accidents? Explain:

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Do you have a family history of any of the following?

- Heart/circulation problems
- Diabetes
- Cancer
- Depression
- Allergies
- Osteoporosis

How many bowel movements do you have daily? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ If you quit, when? \_\_\_\_\_

Do you have mercury amalgam fillings? How many? \_\_\_\_\_

Have you had any dental problems?

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Have you had recent antibiotic treatment? When and for what?

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Have you ever had Candida? (yeast infection)

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Have you had other fungal infections?

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Do you get colds and flu often?

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Do you have a childhood history of infections? (Ear, sinus, throat, urinary tract, kidney, etc)

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Have you ever been exposed to toxic environmental substances? What and when?

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Are you on any special diet?

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Are there any foods you feel bother you in any way?

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Are there foods you crave?

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Do you drink any of the following and if so how much per day?

- Soft drinks            per day: \_\_\_\_\_
- Fruit juices            per day: \_\_\_\_\_
- Coffee                 per day: \_\_\_\_\_
- Alcohol                per day: \_\_\_\_\_
- Milk                    per day: \_\_\_\_\_
- Tea                     per day: \_\_\_\_\_
- Water                  per day & what type: \_\_\_\_\_

How often do you eat in restaurants?

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How often do you eat raw foods?

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Do you feel tired or sleepy after meals?

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Any symptoms if you skip meals?

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How often do you eat bread and what kind is it?

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How often do you eat pasta and what kind is it?

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Is there anything you have experienced after which you could say your health has never been the same since?

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