everyday EVOLUTIONS

Personal History

Name _____ Date _____

Have you consistently or are currently experiencing any of the following?

	WHEN?		WHEN?		WHEN?
☐	____ Abdominal Pain	☐	____ Diarrhea	☐	____ Miscarriage
☐	____ Addiction Problems	☐	____ Digestive Problems	☐	____ Menopausal Symptoms
☐	____ Allergies	☐	____ Dizziness	☐	____ Pre Menstral Symptoms
☐	____ Arthritis	☐	____ Exhaustion/Fatigue	☐	____ Respiratory Problems
☐	____ Asthma	☐	____ Fainting	☐	____ Sinus Problems
☐	____ Bladder/Kidney Problems	☐	____ Headaches	☐	____ Skin Problems
☐	____ Blurred/Double Vision	☐	____ Heart Problems	☐	____ Sleeping Problems
☐	____ Circulatory Problems	☐	____ High Blood Pressure	☐	____ Stomach Ulcers
☐	____ Constipation	☐	____ Low Blood Pressure	☐	____ Thyroid Umbalance
☐	____ Diabetes	☐	____ Menstral Irregularity	☐	____ Varicose Veins

Have you had any major injuries, emotional/mental stresses, diseases, illnesses or surgeries? Please list, including time frame and any current effects

Illnesses on your father's side of the family

Illnesses on your mother's side of the family

Are you currently under a physician's care? If yes, please explain

Date of last physical exam? Results?

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Personal History

PLEASE LIST ANY OF THE FOLLOWING THAT YOU ARE CURRENTLY TAKING OR CONSUMING:

Prescription Drugs _____

Non Prescription Drugs _____

Vitamins or Nutritional Supplements _____

Herbal Teas or Capsules _____

Alcoholic Beverages _____

Tobacco Products _____

Do you have a healthy diet?

Always _____ Most of the Time_____ Sometimes _____ Rarely_____ Not at all_____

Do you currently engage in an exercise routine or physical activity?

1X per day _____ More than 1X per Week _____ 1X per Week _____ Seldom _____ Not at all___

What type of exercise or activity? _____

How many children live at home with you? _____

Do you enjoy your work? _____

What is your level of happiness in your major relationships? _____

What do you consider to be major life stressors?

Female Clients

Date of last menstral peroid ____ Are your pregnant?_____ If Yes, how many months? _____

Are you breast feeding?_____ If yes, how long? _____ How many pregnancies? _____

How many children do you have? Please list gender and ages.

_____

Other Comments