Pure Health Restored

New Patient Health Form

Name ---------- Date of birth: _____

Today's date: _____

Medical Information

How would you describe your present state of health?
☐Very healthy ☐Healthy ☐Unhealthy ☐Unwell ☐Other:
_____

List current medications, how often you take them, and dosages (include prescriptions and over-the-counter medications). Attach a separate sheet if needed.
_____
_____
_____
_____

Do you take all of your medications as they have been prescribed by your healthcare provider? ☐Yes ☐No
If not, please share why (e.g., cost, side effects, or feeling as though they are unnecessary). _____
_____
_____

Do you take any vitamins, minerals, or herbal supplements? ☐Yes ☐No
If yes, list type and amount per day:

_____
_____
_____

When was the last time you visited your physician? _____

Have you ever had your cholesterol checked? ☐Yes ☐No
If yes, date of test: _____

What were the results? _____

Total cholesterol: _____ High-density lipoprotein (HDL): _____

Low-density lipoprotein (LDL): _____ Triglycerides: _____

Have you ever had your blood sugar checked? ☐Yes ☐No
What were the results? _____

Please check any that apply to you and list any important information about your condition:

- ☐ Allergies (Specify: _____)
- ☐ Amenorrhea
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Celiac disease
- ☐ Chronic sinus condition
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diarrhea
- ☐ Eating disorder
- ☐ Gastroesophageal reflux disease (GERD)

- ☐ High blood pressure
- ☐ Hypoglycemia
- ☐ Hypo/hyperthyroidism
- ☐ Insomnia
- ☐ Intestinal problems
- ☐ Irritability
- ☐ Irritable bowel syndrome (IBS)
- ☐ Menopausal symptoms
- ☐ Osteoporosis
- ☐ Premenstrual syndrome (PMS)
- ☐ Polycystic ovary syndrome (PCOS)
- ☐ Pregnant
- ☐ Skin problems
- ☐ Ulcer
- ☐ Major surgeries: _____

- ☐ Past injuries: _____

- ☐ Describe any other health conditions not addressed by this list:

  _____
  _____
  _____

Family History

Has anyone in your immediate family been diagnosed with the following?

- ☐ Heart disease If yes, what is the relation? _____
  Age of diagnosis: _____

☐ High cholesterol If yes, what is the relation? _____
Age of diagnosis: _____

☐ High blood pressure If yes, what is the relation? _____
Age of diagnosis: _____

☐ Cancer If yes, what is the relation? _____
Age of diagnosis: _____

☐ Diabetes If yes, what is the relation? _____
Age of diagnosis: _____

☐ Osteoporosis If yes, what is the relation? _____
Age of diagnosis: _____

Nutrition

What are your dietary goals?

_____

Have you ever followed a modified diet? ☐Yes ☐No

If yes, describe:

_____

Are you currently following a specialized eating plan (e.g., low-sodium or low-fat)?
☐Yes ☐No If yes, what type of plan?

_____

Why did you choose this eating plan?

_____

Was the eating plan prescribed by a physician? ☐Yes ☐No

How long have you been on the eating plan? _____

Have you ever met with a registered dietitian or attended diabetes education classes?
☐Yes ☐No
If no, are you interested in doing so? ☐Yes ☐No

What do you consider to be the major issues with your nutritional choices or eating plan (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety)?

_____

_____

How many glasses of water do you drink per day? _____ 8-ounce glasses

What do you drink other than water? List what and how much per day.

_____

Do you have any food allergies or intolerance? ☐Yes ☐No If yes, what?

_____

Who shops for and prepares your food?
☐Self ☐Spouse ☐Parent ☐Minimal preparation

How often do you dine out? _____ times per week

Please specify the type of restaurants where you dine out/take out.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you crave any foods? ☐Yes ☐No If yes, please specify:

_____

Additional information: if needed, feel free to elaborate more below about your diet, current use of supplements, and medication or any other health concerns.

Substance-related Habits

Do you drink alcohol? ☐Yes ☐No

If yes, how often? _____ times per week Average amount? _____

Do you drink caffeinated beverages? ☐Yes ☐No

If yes, average number per day: _____

Do you use tobacco? ☐Yes ☐No

If yes, how much (cigarettes, cigars, or chewing tobacco per day)?

_____

Physical Activity

Do you currently participate in any structured physical activity? ☐Yes ☐No

If yes, please describe:

_____ minutes of cardiorespiratory activity, _____ times per week

_____ muscular-training sessions per week

_____ flexibility-training sessions per week

_____ minutes of sports or recreational activities per week

List sports or activities you participate in:

_____

Do you engage in any other forms of regular physical activity? ☐Yes ☐No

If yes, describe:

_____

Have you ever experienced any injuries that may limit your physical activity? ☐Yes ☐No

If yes, describe:

_____

Do you have any physical-activity restrictions? ☐Yes ☐No

If so, please list:_____

What are your honest feelings about exercise/physical activity?

_____

What are some of your favorite physical activities?

_____

Occupational

Do you work? ☐Yes ☐No

If yes, what is your occupation? _____

What is your work schedule? _____

Describe your activity level during your work day:

_____

Sleep and Stress

How many hours of sleep do you get at night? _____

Rate your average stress level from 1 (no stress) to 10 (constant stress) _____

What is most stressful to you?

_____

How is your appetite affected by stress? ☐Increased ☐Not affected ☐Decreased

Weight History

What is your present weight? _____ ☐ I don't know

What would you like to do with your weight?

☐Lose weight ☐Gain weight ☐Maintain weight

What was your lowest weight within the past 5 years? _____

What was your highest weight within the past 5 years? _____

What do you consider to be your ideal weight (the sustainable weight at which you feel best)? _____ ☐ I don't know

What are your current waist and hip circumferences?

_____ Waist _____ Hip ☐ I don't know

7. What is your current body composition? _____% body fat ☐ I don't know

Goals

1. On a scale of 1 to 10, how likely are you to adopt a healthier lifestyle (1 = very unlikely; 10 = very likely)? _____

2. Do you have any specific goals for improving your health? ☐Yes ☐No

If yes, please list in order of importance.

_____

_____

3. Do you have a weight-loss goal? ☐Yes ☐No If yes, what is it?

_____

4. Why do you want to lose weight?

_____