OAKS HEALTH CONSULT

Confidential Health History/Intake Form

Please type or write or print clearly

Age: Height: Weight: Place of Birth:

Current weight: Weight six months ago: One year ago:

Would you like your weight to be different? If so, what?

Relationship status: Children?

Occupation: Hours of work per week:

Please list your main health concerns:

When was the last time you felt really vibrant and well?

Other current major life concerns?

If you could wave a magic wand and change 2 things about your life right now, what exactly would they be?

Any serious illness, hospitalization, injuries, and surgeries, either now or in your past?

How is the health of your mother? If deceased, relay illnesses.

How is the health of your father? If deceased, relay illnesses.

What is your ancestry? What blood type are you?

Do you sleep well? How many hours? Do you wake up at night?
Why?

Any ongoing sources of inflammation (e.g. eczema or other skin irritation, chronic post nasal drip, congestion, headaches, achy muscles/joints, swelling, pain, stiffness)?

This section for women only

Are your periods regular? How many days is your flow? How frequent?
Painful or symptomatic? Please explain:
Birth control history:
Vaginal infections, reproductive concerns?

Do you struggle with Constipation, Diarrhea, Gas, Distension, Belching, or Bloating? Which?

Explain in detail:

Please list ALL supplements or medications you take (prescription or over-the-counter) and frequency?

Have you ever taken antibiotics more than a short course or two as a child? If so, when/how often? For what? And for how long?

Any remarkable exposure to toxins (e.g. current or childhood home, nearby industrial community, job, hobbies, travel, pesticides, heavy metals)?

What is the general status of your dental health/care?
Any troubling dental work or history of dental/oral infections? Dentures? Root canals?

How many silver/mercury fillings do you have? Other major dental work/issues beyond basic cleanings?

On a scale of 1 to 10, how would you rate your general energy level (1=lowest)?
To what do you attribute this energy level?

Any healers, helpers, pets or therapies with which you are involved? Please list:
What are your primary hobbies?

What role do sports and exercise play in your life?
What do you do to relax? How often?

What was your general health and well-being as a child?

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you have any known food allergies or sensitivities?

What percentage of your food is home-cooked? What percentage is not?

Where do you get the rest from?

If you have a general philosophy, mindset or approach you use when choosing foods, please describe it briefly.

Do you crave sugar, carbs, alcohol, coffee, cigarettes, other foods, or have any addictions?

Anything else you would like to share?

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Symptom Questionnaire

Please use this scale to rate the frequency and severity of symptoms you have experienced <u>over the past two years</u>. If multiple choices are given, please specify what applies in the comment column.

- ☐ Leave the score **blank** if you **Never** have the symptom.
- ☐ Use a **1** if you **Occasionally** have it and the effect is **Mild**.
- ☐ Use a **2** if you **Occasionally** have it and the effect is **Severe.**
- ☐ Use a **3** if you **Frequently or Consistently** have it and the effect is **Mild**
- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
HEAD	Headache		
	Faintness		
	Dizziness		
	Insomnia		
NOSE	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
MOUTH	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore throat, hoarseness, or loss of voice		
	Swollen or discolored tongue, gums, or lips		
	Chronic tooth or gum pain or jaw pain. Which?		
	Canker sores		
SKIN	Acne		
	Hives or other allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
	Flushing or hot flashes		
	Frequently feel cold		
	Excessive sweating		
	Part of body frequently feeling numb. Which?		
HEART	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain		
LUNGS	Chest congestion		
	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing		
DIGESTION	Nausea or vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Intestinal or Stomach pain. Which?		
	Other pain in GI tract? Where?		

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- ☐ Use a **4** if you **Frequently or Consistently** have it and the effect is **Severe**.

Category	Symptom	Score	Comments or Details, if appl.
JOINTS AND MUSCLES	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Tremor or restless leg		
	Feeling of weakness or tiredness		
WEIGHT	Binge eating/drinking		
	Craving certain foods		
	Excessive weight		
	Compulsive eating		
	Water retention		
	Underweight		
ENERGY	Fatigue, sluggishness		
	Apathy, lethargy		
	Hyperactivity		
	Restlessness		
MIND	Poor memory		
	Confusion, poor comprehension		
	Poor concentration or focus		
	Poor physical coordination		
	Difficulty in making decisions		
	Stuttering or stammering		
	Learning disabilities		
MOOD	Mood swings		
	Anxiety, fear, nervousness		
	Anger, irritability, aggressiveness		
	Depression		
	Other mood challenges?		
OTHER	Frequent illness		
	Frequent or urgent urination		
	Inability to urinate or low urine flow		
	Low libido or other sexual dysfunction		
	Genital itch or discharge		
	Women: Breast fibroids		
	Women: Painful or tender breasts		
	Women: Uterine fibroids		
	Other		
	Other		
	Please tally your scores for this update here:	0	**Total Symptom Score**

Any further comments you wish to share?	

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