Men's Health History

Please write or print clearly. All of your information will remain confidential.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Email: _____ How often do you check email? _____

Phone: Home: _____ Work: _____ Mobile: _____

Who may I thank for referring you? _____

What is your preferred method(s) of communication when not in-person (check all that apply)?

Telephone: ☐ Text: ☐ Email: ☐ FB Messenger: ☐ Other: _____

What is your preferred method(s) of receiving information/learning more about a subject (check all that apply)?

Books: ☐ Articles: ☐ Blogs: ☐ Documentaries: ☐ Brief Videos: ☐ Research Statistic/Studies: ☐

Age: _____ Height: _____ Birthdate: _____ Place of Birth: _____

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

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

SOCIAL INFORMATION

Relationship status: _____

Children: _____

Where do you currently live? _____ Pets: _____

Occupation: _____ Hours of work per week: _____

Other Social Activities that you are involved in: _____

_____ Frequency: _____

HEALTH INFORMATION

Please list your main health concerns: _____

_____

_____

_____

Other concerns and/or goals? _____

_____

Where in your life do you feel that you are lacking organization or have lost control? _____

_____

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries? _____

_____

How is/was the health of your mother? _____

How is/was the health of your father? _____

Do you have siblings? How is their health? _____

_____

What is your ancestry? _____ What blood type are you? _____

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness, or swelling? _____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

MEDICAL INFORMATION

Do you take any supplements or medications? Please list: _____

_____

_____

Any healers, helpers, or therapies with whom you are involved? Please list: _____

_____

Do you believe that there are other areas of your life that may be affecting your overall health (For better or for worse)?

Yes: ☐ No: ☐ If Yes, then which areas? _____

_____

What role do sports and exercise play in your life? (Frequency) _____

_____

_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

FOOD INFORMATION (continued)

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you cook? _____ What percentage of your food is home-cooked? _____

What do you eat/drink at work? _____

Where do you get the rest of your food from, if not from home? _____

_____

What would your ideal eating situation look like on a weekly basis? How often at home/restaurants? _____

_____

Where would you like to be a month from now with your eating situation? 3 months from now? _____

_____

What is working for you in your day to day life, concerning food? _____

What isn't (also known as "Where are you most challenged")? _____

Do you crave sugar, chocolate, soda, energy drinks, coffee, tea, cigarettes, alcohol, drugs or have any other addictions?

_____

How much are you spending on food weekly? (Grocery, farmer's markets, gas stations) _____

How much are you spending eating out weekly? (Restaurants, Coffee Shops, Fast Food) _____

ADDITIONAL COMMENTS

Anything else you would like to share? _____

_____

_____

_____

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