Integrative Roots Health History

This information is confidential and will not be released without written authorization.

Name____**Age**_________

What are your health concerns? ____

____

Allergies____

Current Medications (include non prescription & supplements)_________________________

____

____

____

Surgeries (include your age and/or date)____

____

Other hospitalizations, reason, age and/or date_____________________________________

____

Medical Illness (circle those you have had): High blood pressure Diabetes Heart Disease
Cancer Arthritis Thyroid Disease Depression Other_______________________________

Broken bones or serious injury____

CHILDREN ONLY
Birth weight___________ Vaginal delivery or C-section?___________________

How did you find out about our office? _______________________________________

Who else is on your "healing team" – other health care providers _______________

Nutrition Questionnaire

Please answer the following questions to the best of your ability.

Pre-Natal, Natal, and Post-Natal Nutrition

Did your biological parents have any food allergies, intolerances, or sensitivities?

- ☐ Yes (please describe) ____
- ☐ No
- ☐ Unsure

Were you fed breastmilk or formula as an infant?

- ☐ Breastmilk
- ☐ Formula
- ☐ A combination of breastmilk and formula
- ☐ Unsure

Do you know the age at which you began eating solid foods?

- ☐ Yes (please provide an age) ________
- ☐ No

As an infant, did you experience any food allergies, intolerances, or sensitivities?

- ☐ Yes (please describe): ____
- ☐ No
- ☐ Unsure

Pediatric Nutrition and Eating Patterns

As a child or adolescent, did you experience any reactions to foods?

- ☐ Yes (please describe): ____
- ☐ No
- ☐ Unsure

Did you have consistent, reliable access to healthy foods (i.e., fresh fruits, vegetables, and other nutrient-dense foods) during your childhood and adolescence?

- ☐ Yes
- ☐ No
- ☐ Unsure

As a child or adolescent, were you diagnosed with an eating disorder, or did you have any negative experiences concerning food and body (i.e., frequent dieting, bullying, over-exercising, etc.)?

- ☐ Yes (please describe, mentioning level of care and dates): ____________________________
- ☐ No
- ☐ Unsure

Adult Nutrition and Current Eating Patterns

Are you currently experiencing an eating disorder, or do you experience other disruptive or disordered behaviors concerning food and body (i.e., binge eating, restricting food(s), compensatory exercise, chronic dieting, yo-yo or "crash" dieting, unproductive fixation on "clean" eating, etc.)?

- ☐ Yes (please describe, mentioning level of care and treatment dates as an adult, if applicable): ____
- ☐ No
- ☐ Unsure

What are your favorite foods? ____

What foods do you eat most frequently? ____

Who prepares your food/meals? ____

Who purchases your food? ____

How often do you cook your meals? ____

When in your life did you eat the most nutritious food? _______________________________________

When in your life did you eat the least nutritious food? ____

Miscellaneous

What else would you like me to know about you, your eating habits, nutrition history, and/or relationship to food and body? ____

____

What do you hope to achieve as a result of working with me? _________________________________

____

____

Family History

	Age if Living	Age of Death	Major Illnesses, Cause of Death
Father			
Grandfather			
Grandmother			
Mother			
Grandfather			
Grandmother			
Brothers & Sisters			
Spouse			
Children			

***Circle those diseases other blood relatives (aunts, uncles, cousins have had)*:** cancer, diabetes, heart disease, high blood pressure, stroke, TB, thyroid disease, kidney disease, anemia, migraine, mental illness, depression, suicide, alcoholism, drug abuse, asthma, colon polyps, glaucoma, arthritis, high cholesterol, Other ____

Social and Personal History

Current occupation__________________________________ Educational Level__________________

Married, single, domestic partner________________ Partner's occupation______________________

Who lives at home with you?____

Do you have a spiritual practice from which you derive benefit? ________________________________

Hobbies and Interests____

Do you use tobacco or have you used it in the past? How long?___________How much?___________	Y	N
Are you happy with your weight?	Y	N
Do you feel your diet is healthful?	Y	N
Do you exercise regularly? What form & how often?_________________________	Y	N
Do you feel life is stressful?	Y	N
Do you drink alcohol? If so, when was your last drink?______________________	Y	N
Have you ever had a drinking problem?	Y	N
Do you use marijuana or street drugs?	Y	N

How many caffeine containing beverages do you average per day?___________

Have you been exposed to harmful chemicals or radiation? Y N

Do you have relationship (spouse, family, friends) problems? Y N

Review Of Systems

Check those you ***now*** have or that have been ***significant*** problems in the past.

Fever or chills

Weight change in past 6 months

Fatigue
Headaches

Kidney stones

Fainting or passing out

Dizziness

Trouble with teeth or mouth

Chronic or frequent cough

Coughed or vomited blood

Palpitations

Blood in urine

Night sweats

Chest pain

Skin problems

Difficulty in starting urine

Heat/cold intolerance

Swelling of ankles

Nausea

Jaundice

Indigestion or heartburn

Peptic ulcer

Constipation or diarrhea

Abdominal pain

Bloody or tarry stools

Change in size, shape, or color of bowel movement

Thyroid

Pain or frequent urination

Waking at night to urinate

problems

Vomiting

Trouble with memory

Recurrent backache

Increased thirst/hunger

Joint pains

Numbness or tingling

Sleep problems

Snoring

Nervousness

Depression/crying spells

Difficulty concentrating

Pain in extremities

Memory loss

Fears

Shortness of breath