HEALTH HISTORY AND LIFESTYLE OVERVIEW

Name: _____ Date of Birth: _____Age:_____ Date: _____

Street Address: _____ Phone: ( ) _____

City: _____ State: _____ Zip: _____

Occupation (job title): _____ ( ) Right-handed ( ) Left-handed

Physicians caring for you: _____

_____

Please tell us what is bothering you. If this involves a specific health condition or illness, please tell us about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach a sheet if more space is required).

_____

_____

_____

_____

_____

_____

Is your health currently getting better, worse, or staying the same? _____

What would you like to have happen as a result of this consultation? _____

_____

_____

_____

Please list any medical problems you have and all previous surgeries:

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Use additional space to give information as needed about these conditions

List all medications (prescription and non-prescription) that you take now. _____

_____

_____

_____

List any other medications that have been tried in the past to treat your symptoms: _____

_____

_____

Please list any allergies you have: _____

_____

_____

What other treatments, if any, have you tried? Put a star by those that have helped. _____

_____

_____

_____

How would you describe your health in general? _____

During the last year have you had: (check all that apply)

( ) unexplained fevers	( ) night sweats	( ) weight loss of 10 lb. or more
( ) loss of appetite	( ) excessive fatigue	( ) problems with depression
( ) difficulty sleeping	( ) easy bruising	( ) unusual stress in home life
( ) chest pain or tightness	( ) easy bleeding	( ) unusual stress in work life
( ) persistent or unusual cough	( ) swollen ankles	( ) any lumps in neck, armpits, or groin
( ) coughing up blood	( ) stomach pain	( ) trouble breathing with exercise
( ) change in bowel habits	( ) persistent diarrhea	( ) trouble breathing when lying flat
( ) dark black stools	( ) excessive constipation	( ) difficulty starting or stopping urination
( ) bleeding on stools	( ) blood in urine	( ) pain or burning when urinating

What other health practices do you incorporate into your lifestyle at the present time? _____

_____

_____

_____

_____

How familiar are you with Edgar Cayce and his work? (circle one):

Not familiar 1 2 3 4 5 6 7 8 9 10 Most familiar

How closely do you follow the recommendations in the Cayce health readings? (circle one number in the range):

Not at all 1 2 3 4 5 6 7 8 9 10 Closely

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

a.

b.

c.

d.

e.

Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, I need some help... let's change some things here!" Please explain:

_____

_____

_____

Do you feel your pain and/or illness is a reflection of short-term superficial circumstances or longer term, potentially deeper-seated challenges?

_____

_____

What areas of your lifestyle are likely involved with your condition and you would like to improve:
(Prioritize # 1, 2, 3, etc.)

_____ My level of anxiety

_____ My pace of living

_____ Not enough quiet time and rest

_____ Diet and nutrition program

_____ My exercise program

_____ Not enough time spent in nature

_____ My creative expression

_____ My feelings around career

_____ My social and family life

_____ My communication skills

Please list any self-destructive lifestyle habits (e.g. smoking, lack of exercise, addictions, etc.)

_____

_____

_____

What might it cost you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

_____

_____

What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10,
with 10 being 100% committed). _____

List your 3 highest priorities in life, which come to mind and speak to your heart. Where does your health and vitality factor in?
a.

b.

c.

What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

_____

_____

What might stop you from following the plan that we may recommend for you?

_____

_____

Who would be willing to support you in your health goals?

_____

_____

Please list your special interests and passion:

_____

_____

Women only:

Age at onset of menstruation: _____ No. of miscarriages/c-sections:
_____

Number of children: _____ Age at onset of menopause: _____

How was your health as a child? (circle one): excellent good fair poor

Did you have any serious emotional or mental traumas as a child? _____ Please explain:

_____

_____

_____

_____

What is your blood type? (circle one): A B AB 0 don't know

Do you wake rested? _____

Please rate your current emotional health (please circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy? _____ Do you have a good support network/team? _____

Does your home environment have a supportive effect on your health? _____

How many hours of relaxation (not including sleep) do you give yourself during the work week? _____

During weekends? _____ Favorite recreational activities? _____

Do you have amalgam (silver) fillings?_____ Any other dental problems? _____

Are you considering any elective surgery or medical procedures in the near future? _____

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check if your blood relatives have/had Disease		Relationship
Father						Arthritis, gout	
Mother,						Asthma, hay fever	
Brothers						Cancer	
						Chemical dependency	
						Diabetes	
						Heart disease, stroke	
Sisters						High blood pressure	
						Syphilis, gonorrhea	
						Tuberculosis	
						Other	

Please list everything you eat and drink for the next 3 days: (not the 3 days prior to testing)

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

Is there anything else you would like us to know about you?