www.healthrethink.org

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Health Evaluation

Date: ______________________________

Name: ______________________________

Gender: ______________________________

Address: ______________________________

Phone: ______________________________

Email: ______________________________

DOB: ______________________________

Profession: ______________________________

Emergency Contact: ______________________________

____

BP:

HR:

Wt:

Ht:

Wt goal:

Previous Doctors:

- ○ MD
- ○ Functional Medicine
- ○ Integrative Medicine
- ○ Naturopathic Dr
- ○ Chiropractic Dr

Please provide copies of any blood tests done and any medical reports for the last 5 years (as per availability).

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____

____

History

Prescription **medications** (regular or other)

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____

____

____

Herbal supplements you are taking

____

____

List all **vitamin** or minerals supplements you are taking

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____
____
____

List all **probiotics**

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____
____
____

List all **essential oils** you use from time to time

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____
____
____

List medical **diagnosis** you have received (unless medical reports have been shared with us)

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____
____
____

List any **surgeries** you have had

____
____
____
____

List any food **sensitivities** you are aware of

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____
____
____

Please tick off any of the following hazards that you have exposure to regularly:

- ○ Hazardous chemicals (including household cleaning agents)
- ○ Air fresheners, deodorants, perfumes
- ○ Polluted air
- ○ Polluted water
- ○ Radiation
- ○ Soap (you can list your commonly used brand) ________________________________
- ○ Shampoo ____
- ○ Toothpaste ____

Check all symptoms you are currently experiencing and briefly describe. List any further details about these symptoms you'd like to include.

- ○ Dizziness ______________________________
- ○ Numbness ______________________________
- ○ Tingling ______________________________
- ○ Migraine headache ______________________________
- ○ Unbalanced gait ______________________________
- ○ Shortness of Breath ______________________________
- ○ Chronic cough ______________________________
- ○ Palpitations ______________________________
- ○ Chest pain ______________________________
- ○ Swelling ______________________________
- ○ History of High Blood Pressure (BP) ______________________________
- ○ Heart burn ______________________________
- ○ Bloatting ______________________________
- ○ Abdominal pain ______________________________
- ○ Abdominal cramps ______________________________
- ○ Diarrhea or constipation ______________________________
- ○ How often do you have bowel movements? ______________________________
- ○ Do you have silver fillings in your teeth? If so, how many, and for how long? ______________________________
- ○ Do you have bleeding gums? If so, please elaborate. ______________________________
- ○ List any further details about these symptoms you'd like to include.

____
____
____
____
____

Habits and Lifestyle

Sample of your average **Breakfast**

____
____
____
____
____
____

Sample of your average **Lunch**

____
____
____
____
____
____

Sample of something you commonly **snack** on

____
____
____
____
____

Sample of **Dinner**

____
____
____
____
____
____

What is your largest meal of the day?

____
____

Do you drink liquid with your meals?

____
____

How long before going to bed do you eat?

____
____

History of Diabetes? Type? How long?

____
____

History of Thyroiditis? Type? How Long?

____
____
____

Please tick off which of the following items you use regularly of from time to time.

- ○ Tobacco
- ○ Alcohol
- ○ Chips
- ○ Crackers
- ○ Cookies
- ○ Chocolate
- ○ Candy
- ○ Sugary snacks
- ○ Refined Sugar
- ○ Artificial Sweetener
- ○ Ice Cream
- ○ Carbonated Drinks
- ○ Fruit Juices
- ○ Green Juices
- ○ Coffee
- ○ Milk
- ○ Cheese
- ○ Butter
- ○ Margarine
- ○ Vegan cheese
- ○ Vegan butter
- ○ Eggs
- ○ Fish
- ○ Meat
- ○ Fast Foods
- ○ Fried Food
- ○ Luncheon Meats
- ○ Gluten, Oats, Soy, Corn, yeast
- ○ Processed Vegan Products
- ○ Type of Salt

Sleep and Sunshine

When do you go to sleep and when do you wake up?

____
____

How often do you wake up in the middle of the night?

____
____

Do you go back to sleep easily?

____
____

Do you have a history of sleep apnoea?

____
____

Do you take naps?

____
____

Do you have rest days? If so, which days?

____
____

Do you sunbathe? If so, how often and how long?

____
____

Do you use sunscreen?

____

Exercise

What is your favourite kind of exercise? ______________________________
How often do you do exercise, and for how long per session? ________________
Describe your exercise program please. ______________________________

Water

How much water do you drink every day? ______________________________

Air

Do you have access to a home with regular fresh air? ____________________
Does your bedroom have fresh air every day? ________________________

Emotional Health

How would you rate your stress?

Do you suffer from depression?

Do have a lot of fears?

Do your emotions feel uncontrollable?

Are you experiencing grief?

Are you discontent with your life?

Final Questions

Do you attend a church or have religious fellowship with like-minded people?

Do you believe God can heal you?

What goals do you have?

What is your life’s purpose?

What do you want to accomplish with this program?

What is your motivation making these changes? Family? Children?

Dr Jade Erasmus

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