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Health & Lifestyle Assessment Form

EcoHealth & Wellness wants to assure you that all of the information provided below will remain strictly confidential.

CONTACT INFO:

Patient Name: _____ Date: _____

Date of Birth: _____ Current Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Email _____

Highest level of education: _____

Occupation: _____ Employer _____ Hours work per week: _____

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Person to call in case of Emergency: _____

Relationship to you: _____

Phone number contact for them: _____

Primary Care Physician: _____

Physician Office Phone: _____

Physician Office Address: _____

Last time you had blood work done and with what doctor: _____

- (please bring copies of your most updated blood work to your appointment)

How did you hear about EcoHealth & Wellness _____



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List in Order of Importance what your problems are:

- 1.
- 2.
- 3.
- 4.
- 5.

Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please Note When and Why You Had Each of The Following:

X-rays: _____

MRI/Cat Scans: _____

Ultrasounds: _____

Accidents: _____

List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____



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Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diphtheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Any vaccination reactions: _____

List Yes, No, or Past regarding use of the following:

Antacids:	Y N P	Steroids:	Y N P
Smoking:	Y N P	Packs per day if Yes/Past:	_____
Analgesics:	Y N P	Laxatives:	Y N P
Coffee:	Y N P	Cups per day if Yes/Past:	_____
Soda Pop:	Y N P	Ounces per day if Yes/Past:	_____
Diet Soda	Y N P	How often and how much if Yes/Past:	_____
Alcohol:	Y N P	How often and how much if Yes/Past:	_____
Any alcohol addiction:	Y N P		
Any alcohol treatment:	Y N P		
Recreational drugs:	Y N P		
Any drugs addiction:	Y N P		
Any drug treatment:	Y N P		
Have you ever had food poisoning:	Y N P		

List all Medications (prescription or over the counter) you are currently taking:

Medications	Condition	Dosage	Times per day



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List all Nutritional Supplements, Vitamins and Herbs you are currently taking:

Supplements (list brand name)	Condition	Dosage	Times per day

Review Of Systems:

Present Weight: _____ Weight one year ago: _____
 Height: _____ Maximum weight and when: _____
 Minimum Weight as adult and when: _____
 Ideal Weight: _____

BLOOD TYPE _____ (if known)

REGARDING THE NEXT SECTION: Please Circle Y (for YES) if you have the problem NOW, N if you've NEVER had the problem, P if you had the problem in the PAST.

Fatigue: Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst?: _____

If you have fatigue, can you do what you need to during the day?: Y N



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Skin:

Rash: Y N P
Hives: Y N P
Psoriasis/eczema: Y N P
Dry: Y N P
Cancer: Y N P

Color Change: Y N P
Lump: Y N P
Itchy: Y N P
Warts/moles: Y N P
Perspiration: Y N P

Head:

Headache: Y N P
Dandruff: Y N P
Oil/dry hair: Y N P

Migraine: Y N P
Head Injury: Y N P
Hair loss: Y N P

Eyes:

Dry/Watery: Y N P
Double vision: Y N P
Glaucoma: Y N P
Strain: Y N P
Itchy: Y N P

Blurry vision: Y N P
Cataracts: Y N P
Styes: Y N P
Discharge: Y N P
Dark under eyelid: Y N P

Nose:

Frequent colds: Y N P
Congestion: Y N P
Polyps: Y N P

Nosebleeds: Y N P
Post nasal drip: Y N P
Seasonal allergies: Y N P

Mouth/Throat:

Canker sores: Y N P
Sore throat: Y N P
Dentures: Y N P
Loss of taste: Y N P

Cold sores: Y N P
Gum disease: Y N P
Cavities: Y N P
Hoarseness: Y N P

Neck:

Stiffness: Y N P
Full movement: Y N P

Swollen glands: Y N P
Tension: Y N P

Respiratory:

Cough: Y N P
Shortness of breath with exertion: Y N P
Shortness of breath sitting: Y N P
Shortness of breath lying down: Y N P
Wheezing: Y N P

TB: Y N P
Bronchitis: Y N P
Pneumonia: Y N P
Asthma: Y N P
Painful breathing: Y N P



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Cardiovascular:

High blood pressure: Y N P
Low blood pressure: Y N P
Arrhythmias: Y N P
Edema: Y N P

Rheumatic Fever: Y N P
Murmurs: Y N P
Palpitations: Y N P
Chest pain: Y N P

Gastrointestinal:

Heartburn: Y N P
Indigestion: Y N P
Bloating: Y N P
Nausea : Y N P
Vomiting: Y N P
Change in Appetite: Y N P
Pancreatitis: Y N P

Bowel movement frequency: _____
Recent change in BM: Y N P
Diarrhea or constipation: Y N P
Hemorrhoids: Y N P
Gall bladder disease: Y N P
Liver disease: Y N P
Ulcer: Y N P

Urinary Tract:

Incontinence: Y N P
Frequent infections: Y N P
Urgency: Y N P

Pain with urination: Y N P
Kidney stones: Y N P
Discharge/blood: Y N P

Male:

Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P
Impotency: Y N P

Sexually active: Y N P
Sexually transmitted disease: Y N P
Prostate disease/symptoms: Y N P
Sexual orientation: Hetero Homo Bi

Female:

Date of Last Menstrual Cycle: _____
Age periods began: _____
How long periods last: _____
Periods:
Heavy Bleeding: Y N P
Cramping: Y N P
Pain: Y N P
PMS: Y N P
Food Cravings: Y N P
Last Pap Smear: _____
Diagnosis: _____

How often periods occur: _____
Menopausal since what age: _____
Times Pregnant: _____
How many births: _____
Miscarriages: _____
Abortions: _____
Sexual Active: Y N P
Healthy Libido: Y N P
Pain With Intercourse: Y N P
Dry Vagina: Y N P



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Food:

Question	Yes	No
Over the years have you noticed an increased sensitivity to sweets or white bread/flour foods resulting in increased irritability, tiredness, or depression?		
Are you preoccupied with certain foods and the thought of food?		
Have you every lied about how much sweet food or other carbs you eat?		
Are sugar/carbs controlling your life?		
Are you a vegetarian? If yes, what type <ul style="list-style-type: none"> • Vegan- (plan products only) • Lactovegetarian (plant and dairy products) • Ovolactovegetarian (plan, dairy and egg) • Fruitarian (fruits, nuts, honey and vegetables only) 		

Appetite Good?: Y N P

Foods you Crave: _____

Foods you Dislike: _____

Foods that don't sit well: _____

Current Nutritional Intake

In order to accurately assess your current nutrient intake, we need to understand your current eating habits. Please fill out the following nutritional summary in detail for what you consider your AVERAGE HEALTHY EATING HABITS and MOST UNHEALTHY eating day. This gives us an idea of your strengths and weaknesses and enable us to make suggestions for positive change. List the foods in portions you eat, not those you plan to eat.

- Be specific with portion sizes. If you do not know who many ounces or cups something is, give us a reference. For example: 1 large apple (baseball sized) broiled chicken (about the size of 2 decks of cards)
- Include any extras you may consume such as cream or sugar in coffee, after dinner mints, gum, candy, etc.
- Don't forget to list beverages (Diet Coke, Coffee, water, juice, green tea, alcohol, etc.



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Healthiest Day

Meal/ Snack Time	Food	Portion Size or Estimation	Comments
Breakfast Time:			
Morning Snack Time:			
Lunch Time:			
Afternoon Snack Time:			
Dinner Time:			
Evening Snack Time:			
Before Bed Snack Time:			



Most Unhealthy day

Meal/ Snack Time	Food	Portion Size or Estimation	Comments
Breakfast Time:			
Morning Snack Time:			
Lunch Time:			
Afternoon Snack Time:			
Dinner Time:			
Evening Snack Time:			
Before Bed Snack Time:			



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Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?: _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?: _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?: _____

Are you particularly sensitive to perfumes, gasoline, or other vapors?: _____

Do you use pesticides, herbicides, other chemicals around your home? _____

How many dental amalgams/mercury fillings do you have? _____

Social Life:

Enjoy job?: Y N P

Active Spiritual practice: Y N P

Quality of most significant relationship? _____

History of sexual, mental/emotional, physical abuse?: Y N

If so, at what age and by whom?: _____

What is your greatest health concern? _____

How does it limit you the most? _____

How committed are you towards making valuable changes: Little Moderately Very

Please use the rest of the page to write any additional you comments you may have about the reason for your visit.