

Health Assessment

Anatomystery.com
7451 Warner Avenue, Suite E152
Huntington Beach, CA. 92647
Fax (714) 848-8311

Client's Name: _____ Client Referred by: _____
Address _____ City, State & Zip _____
Telephone (best contact #) _____ E-mail address _____

Age _____ Gender _____ Marital Status _____ No. of Children _____ Age of youngest child _____
Ethnicity/Race - Father _____ Mother _____
Comments? _____

Current Height _____ Current Weight _____ Desired Weight _____ Frame Size Sm Med Lg
Weight at Age 18? _____ Weight 1 year ago? _____ Weight 5 years ago? _____
Women Only: Weight prior to first pregnancy? _____ Weight 3 months after first delivery? _____
Weight after last pregnancy? _____ Did you nurse? Yes No Any complications with births? Y N
If yes, please briefly explain _____

Occupation _____ Employer _____
Do you consider your work/lifestyle physically - Strenuous Active Light Sedentary Dangerous?
Days and Times you work? (Example: M-F from 6am-3pm) _____
Do you currently exercise? Yes No How many days a week? _____ How many minutes daily? _____
What type of exercises do you perform? (Example: Curves, Cardio at Gym, Pilates with Tape, Yoga Class).
Please list all types and number of minutes each exercise takes daily _____

Notes: (Counselor only)

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Lifestyle

Counselor notes below:

Do you currently smoke? Yes No If yes, how many daily? _____ If you quit, how long ago? _____

How many years of smoking? _____ Do you drink alcohol? Yes No If so, how often? _____

Do you currently use recreational drugs? Yes No If so, what type(s)? _____

Prescription Medications, Non-prescription Medications, Nutritional Supplements

Please list your current daily regimen for medications and nutritional supplements. Attach an extra sheet of paper if necessary to complete. It is important that you list everything taken.

Medication or Nutritional Supplement Taken	How Long have you taken this medication?	This medication is taken for what purpose?	What exact time of the day do you take this?

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Medical History

Please list any major surgeries _____

What have you ever been diagnosed as having? _____

Please list any allergies _____

Do you have recent blood work? Yes No (Please bring recent lab work with you to your appointment.)

Family Health History

Relative	Age at death	Cause of Death	Any chronic illnesses	Heritage/Ancestry
Maternal Grandfather				
Grandmother				
Maternal Grandfather				
Grandmother				
Father				
Mother				
Siblings				
Children				

Health History (Residential Visitation) *Please list any visits to countries outside the United States*

Place of Visit	When (year)	How Long?	Any illness/symptoms while traveling?

Environmental Exposure *Please list previous employment or activity in which exposure to pesticides, toxic chemicals, heavy metals, cosmetics, paint, electromagnetic fields or nuclear exposure is (was) considered a part of your work.*

Job or Activity	What year (s)?	What exposure

Goals and Health Concerns *What is the primary reason you are seeking a consultation?* _____

Please list any symptoms or concerns (or goals for yourself) that have prompted you to seek counseling.

Other Concerns or Reasons for Counseling	How long have you had this concern?	What symptoms do you notice with this concern?

Health Symptoms Questionnaire

Please circle symptoms and check box indicating the frequency of a symptom. Use the 4th box to indicate the strength of each symptom. 1= minor problem, tolerable, live with it; 2 = major problem when it occurs, requiring medication or bedrest; 3 = chronic problem that may be life-long, forces you to stop your activities, may require visit to doctor, continual medications, resulted in hospital visit or repeated treatments.

Head, Ears, Nose, Eyes	Never	Occasional	Frequent	Strength
Insomnia, sleep apnea, nocturnal fatigue, trouble getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, dizziness, fainting, vertigo, lightheadedness, migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy ears, earaches, ear infections, ringing in ears, drainage in ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watery, itchy eyes, bags or dark circles under eye, tunnel vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection, stuffy or runny nose, hay fever, sneezing attacks, excessive mucus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please make comments here _____				

Mouth, Throat, Lungs	Never	Occasional	Frequent	Strength
Chronic coughing, gagging, need to clear throat, hoarseness, sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen or discolored tongue, swollen gums or lips, dental infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands, strep throat, bleeding gums, abnormal bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest congestion, difficulty breathing, shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, allergies, bronchitis, undetermined chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please make comments here _____				

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Digestion, Skin, Elimination

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Nausea, Vomiting, Diarrhea, Constipation, Water Retention | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloating, Belching, Passing Gas, Heartburn, Stomach/Intestinal Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital Itch or Discharge, Yeast Infections, Herpes Infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Acne, Rashes, Hives, Shingles, Dry or Broken Skin, Excessive Sweating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney infections, Prostate Inflammation, Frequent Urge to Urinate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Please make notes here _____

Joints, Muscles, Energy, Pain and Inflammation

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Pain or aches in joints, arthritis, limitation of movement, lower back pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain or aches in muscles, fibromyalgia, feeling of weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue, feeling of tiredness daily, loss of libido, daily need to nap | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Please make notes here _____

Immunity

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Frequent colds or flu, seasonal allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Toenail infections, Skin Fungus, Hepatitis, HIV or other viruses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer (current or remission), lymphatic issues, transplant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Please make notes here _____

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Heart, Circulation

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Irregular or skipped heartbeat, rapid or pounding heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure, high cholesterol, heart muscle concern, clotting issues | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold hands or feet, easy bruising, varicose veins, erectile dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Please make notes here _____
-

Weight, Metabolic Activity, Brain Function

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Binge eating or drinking, craving certain foods, compulsive eating | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Underweight, eating disorder, loss of appetite, yo-yo dieting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hyperactivity, apathy, lethargy, restlessness, sluggishness, confusion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Memory loss, poor concentration, difficulty making decisions, fear, anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mood swings, nervousness, anger, irritability, aggressiveness, depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Please make notes here _____
-

Female Transitions

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Breakout bleeding, excessive hair, bloating, irregular period, loss of menses | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of libido, night sweats, hot flashes, hormone replacement therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal discharge, dryness, breast tenderness, underarm pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cosmetic surgery, breast enhancement or reduction, botox or collagen injections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Please make notes here _____
-

Please read each section carefully and sign before appointment:

Anatomystery does not share any information provided by clients unless clients request in writing for caregivers, family members, other practitioners or interested parties to receive such confidential information. Anatomystery Consulting provides integrative counseling only and does not practice allopathic medicine. The intent of our services is to educate clients on proper nutrition for quality of life, as well as provide education in practical methods of obtaining optimal health. Anatomystery does not provide medical services, including but not limited to diagnosis, treatment, cure or mangement of any illness or disease.

Please initial here that you have read and understand the above notice. _____

Please expect your consultation to last as long as it takes to find answers. The cost for an initial visit is posted on the site, which includes the health assessment, safety check on medications and/or nutritional supplement, an in-depth consultation, a resulting personalized meal plan and structured follow-up interaction to last for three weeks. This cost does not include nutritional products, which may be recommended.

Please provide your signature here indicating that you have read and understand the above notices regarding our services.

Signature _____

Date _____

IMPORTANT NOTICE: Any client using medications and/or nutritional supplements must list these products in their assessment.

Please initial that you have read and understand the above notice. _____

All credit cards will be processed through PayPal or personal checks are excepted - Please expect this billing name to show up on your statement.

After filling out the assessment, please fax it to the number at the top of these 8 pages. You can also email it back to human@anatomystery.com Anatomystery does not sale products but will mention where they can be found at the best prices, quality and freshness. You will find this service alone pays for the cost of this consultation.

See you in health:

Anatomystery