• I was born in (location)_________________________ with a birthday of ____________(M/D/Y)
• I was born at (put an ‘x’ next to one): Full-term [38+ weeks]___ Premature [<38 week]___ Who Knows___
• I was born by: Vaginal Delivery___ C-Section___ Who Knows___
• I was conceived in: The back of a Volkswagen___ A hotel room___ Okay just kidding… kind of…
• My mother was __________ years old when I was born
• I was the ________ child (only, first, second…) of__________ siblings
• My childhood home social setting was (i.e. nurturing, stable, abusive, typical hot mess)

_________________________________________________________________________________________________________________
• My mother had antibiotics during the pregnancy: Yes___ No___ Who Knows___
• My mother had a prolonged labor and/or antibiotics during her labor with my birth:
  Yes___ No___ Who Knows___
• I had a traumatic or assisted birth (forceps, suction, Jeep winch): Yes___ No___ Who Knows___
• I had colic or breast-feeding problems: Yes___ No___ Who Knows___
• I was breast fed: None___ <3 Months___ 3-6 months___ 6-12 months___ >12 months___
• My household had a garden when I was a child: Yes___ No___Who Knows___
• I routinely played outdoors as a child (<12 years); Yes___ No___ How Often:_______________________
• My first antibiotic exposure was at age: 0-1 years old___1-3 years___ 4-6 years___ 7-10 years___ 11-19 years___ >20 years___ I have never had antibiotics___
• I may have had ________ antibiotic courses before age 6
• I may have had ________ antibiotic courses from ages 6-10
• I may have had ________ antibiotic courses from ages 11-19
• I may have had ________ antibiotic courses from age 20 to current
• The primary reasons for antibiotic use in my life time (‘x’ all that apply): Ears___ Respiratory___
  Strep Throat___ Sinuses___ Intestinal___ Urinary Tract/Kidney___ Skin___ Lyme___
  Other___________________________________________________________________________________________________________
• My diet as a child was (‘x’ all that apply):
  ___Normal American Home Cooked (meat, potatoes, veggies, pasta, salads, pizza, pancakes, cereal, etc)
  ___Mostly from Family or Friend Sources (garden, hunting, fishing)
  ___Mostly Home and healthy restaurants
  ___Mostly Home and some fast food
  ___Mostly fast food
  ___Mostly health restaurants and/or healthy pre-prepared foods
• When I was growing up I remember helping to cook in the kitchen: Sometimes___ Often___
  Occasionally___ Never___
• I started enjoying cooking at age: <10___ 10-19___ 20-30___ 30-40___ Still trying___
• I drink ________ mugs of coffee daily
• My mug is (Regular, Grande, Venti, Super Sized)
• I drink caffeinated tea ________ times a day
• I drink alcohol ________ times a week for a total of ________ drinks
• Presently I cook at home _____ meals per week
• I eat fast food (McDonalds, Taco Bell, Kentucky Fried, Wendy's, etc.)________ meals per week
• I eat healthier fast food (Chipotle, Salad Bars, Juice Bars)________ meals per week
• I prepare my own snacks in the home daily: Yes___ No___ Not on my life___
• My favorite beverage is_____________
• I drink water (‘x’ one): Throughout the day___ With meals___ Only as tea___ Occasionally___ Never___
• My favorite snack is______________________
• I eat before 8 AM (‘x’ one): Everyday ___ A few days a week___ Rarely___ Never___
• I eat after 8 PM (‘x’ one): Everyday___ A few days a week___ Rarely___ Never___
• I eat: Everything I see___ Meat/Potatoes/Veggies___ Pescatarian___ Vegetarian___ Vegan___
• I have tried the following diets: Atkins___ South Beach___ Zone___ HCG___ Paleo___ Ketogenic___
• I have had gastric banding or surgical reduction: Yes___ No___
• I have been treated by surgery for diseases of the: Mouth___ Esophagus___ Stomach___
  Small intestines___ Colon___ None of the above___
• I have environmental allergies/sensitivities (pollen, mold, pet dander, etc): Yes___ No___
• To what (if you know) ________________________________________________________________________________________
• I have food allergies/sensitivities: Yes___ No___
  To: Gluten___ Dairy___ Nuts___ Meat___ Night Shades___ Other _________________________________________________________________________________________________________
• I have Irritable Bowel Syndrome (Bloating after meals, diarrhea/constipation cycles, etc): Yes___ No___
• I have acid reflux or heartburn: Yes___ No___
• I have Inflammatory Bowel Disease (gastritis/ulcers, Crohn's disease, ulcerative colitis, non-specific colitis): Yes___ No___
• I have an autoimmune condition: Yes___ No___
• I have been diagnosed with: Low thyroid___ High thyroid___ Type 1 Diabetes___ Celiac___ Psoriasis___
  Rheumatoid Arthritis___ Other _______________________________________________________________________________
• I have a chronic disease or disorder (‘x’ all that may apply): Depression___ Anxiety___ Sexual dysfunction___ Infertility___ Menstrual disorder___ Menopause symptoms___ High Cholesterol___ Pre-Diabetes___ Diabetes___ Fatty Liver___ Gall Stones___ Kidney Stones___ Chronic Kidney Disease___ Heart Disease___ Lung Disease___ Vascular Disease___ Neurologic Disease or Injury___
• I have insomnia or sleep disorder: Yes___ No___
• I have Sleep Apnea: Yes___ No___
• I have chronic pain: Yes___ No___
  Site(s) of chronic pain:_________________________________________________________________________________________
• I have chronic fatigue: Yes___ No___
My Supplement/Medication List

My dietary supplements include:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

TOTAL Number of supplements:

The top three supplements that I have continued to use over my lifetime are:

________________________________________________________________________

My prescribed medications are:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

TOTAL Number of medications:

I have been on a statin type drug for cholesterol for (current or past) ____________ years   N/A

Recreational Drugs:

________________________________________________________________________
________________________________________________________________________
Life Review

Please circle the number that approximates your sense of health at each stage of life using the following scale:

1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___
Sickly  Average Extremely Healthy

As a child age 12 and under I recall my health to have been:
1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ N/A___

As a teen, age 13-19 years, I recall my health to have been:
1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ N/A___

In my 20’s I recall my health to have been:
1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ N/A___

In my 30’s I recall my health to have been:
1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ N/A___

From 40-60 years of age, I recall my health to have been:
1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ N/A___

I currently consider my health to be:
1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___ N/A___

Compared to my peers I feel:
Below Average___ Average___ Above Average___
Over my life I have been diagnosed with these conditions/diseases:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________