

## INTEGRATION FOR LIFE

### Men's Confidential Health History Please write or print clearly

Name: ..... Address: .....

Email Address: ..... How often do you check email? Facebook? .....

Telephone (Work): ..... (Home) ..... (Cell) .....

Age: ..... Height: ..... Date of Birth: ..... Place of Birth: .....

Current Weight: ..... Weight Six months ago: ..... One year ago: .....

Would you like your weight to be different? ..... If so, what? .....

Relationship status: .....

Children: ..... Pets: .....

Occupation: ..... Do you enjoy your job? ..... Hours of work per week: .....

Please list your main health concerns that you would like to improve, physical or emotional: .....

.....

.....

.....

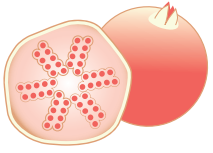
.....

Other concerns and/or goals? .....

.....

At what point in your life did you feel best? .....

.....



# INTEGRATION FOR LIFE

## Men's Confidential Health History (continued) Please write or print clearly

Any serious illnesses / hospitalizations / injuries? .....

How is your digestion? ..... Constipation / diarrhea / gas? .....

How is the health of your father? ..... How is the health of your mother? .....

What is your ancestry? ..... What blood type are you? .....

Do you sleep well? ..... How many hours? ..... Do you wake up at night? .....

Why? .....

Any pain, stiffness or swelling in you body? .....

Antibiotic history (how often) or long term prescription drug use? .....

Explain: .....

Allergies or sensitivities? Please explain: .....

Problems with thyroid? ..... Have you had your cholesterol read? .....

Any current or past diseases, viruses or infections? Any that run in your family? .....

.....

Do you take any supplements or medications? Please list: .....

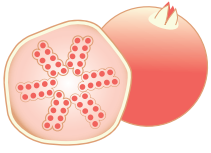
.....

Any healers, helpers or therapies with which you are involved? Please list: .....

.....

What role does sports and exercise play in your life? .....

.....



# INTEGRATION FOR LIFE

## Men's Confidential Health History (continued) Please write or print clearly

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and / or friends be supportive of your desire to make food and / or lifestyle changes? .....

Do you crave sugar, coffee, cigarettes, alcohol or have any major addictions, past or present? (food related or other) .....

.....  
.....

What percentage of your food is home cooked? ..... Do you cook? .....

Where do you get the rest from? .....

The most important thing I should change about my diet to improve my health is: .....

Anything else you want to share: .....

.....  
.....  
.....  
.....  
.....