TOTALITY WELLNESS

Ashley Cummins, RN
Integrative Nutrition Health Coach

Health History Form

Please write or print clearly. All of your information will remain confidential between you and me.

PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____ DOB: _____

Phone Number: _____ Email: _____

Height: _____ Weight: _____ Ideal Weight: _____

SOCIAL INFORMATION

Occupation: _____ Relationship Status:_____

Children: _____ Pets: _____

HEALTH INFORMATION

Medical History: _____

_____

_____

Health Concerns: _____

_____

_____

Allergies or Sensitivities? _____

Medications: _____

Supplements (Please List What They Are Taken For): _____

_____

HEALTH INFORMATION (continued)

Average Hours of Sleep/Night: _____

Do You Exercise? If so, How Frequently? _____

Do You Crave Sugar, Coffee, Cigarettes, or have any major addictions? _____

_____

_____

What physical ailments are you currently experiencing? Check all that apply:

- ☐ Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Lack of Energy
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Memory Issues

ADDITIONAL COMMENTS

Anything else you would like me to know? _____

_____

_____

_____

_____