Perfect Balance
Wellness Project

Welcome! Please fill out this **Health History / Lifestyle Questionnaire**. Then email it back to me at HealthyLivingZone@gmail.com . Thanks!

Client's name: _____ Date of birth: _____

Parent or guardian if client is under 18 years of age: _____

Mailing address:

City: _____ State/Province: _____

Postal / ZIP code: _____ Country: _____

Primary phone number: _____ Alternate phone: _____

Primary email address: _____

What is your occupation? _____

(Optional) Name and phone number of your primary care provider: _____

Please briefly describe your current living situation: _____

Please list your top 5 health goals:

1.
2.
3.
4.
5.

What health-promoting strategies have you already utilized? _____

What's going well with your life and health? What are you passionate about?

1.
2.
3.
4.
5.

Health History

Are you working with any active diagnosed medical conditions? If so, please list: _____
_____

Please list any prescription medications you take: _____
_____

Please list any symptom-relieving OTC medications you take regularly (for instance for heartburn / reflux, allergies, sleep, pain relief) _____

Specifically -- do you take a proton pump inhibitor (PPI) such as Prilosec, Prevacid, or Nexium (full list here: https://www.drugs.com/drug-class/proton-pump-inhibitors.html)? _____

Specifically -- do you use any type of steroid, including inhalers or skin creams? _____

Would you say you've taken antibiotics on a recurrent basis, either recently or as a child? _____

Have you ever taken an "antibiotic cocktail"? If so, when? _____

Do use any type of antimicrobial mouthwash (Listerine, Scope, etc)? If so, what brand? _____

Women: Have you ever used hormone-based birth control pills / patch or used a copper IUD? ____

Please list any supplements (vitamins, minerals, herbs & so on) that you take regularly: _____
_____

History of childhood illnesses and/or viruses such as chicken pox, mono, measles & such. _____
_____

Please list any surgeries (includes removal of wisdom teeth) and year: _____
_____

Do you or a close family member have hypermobile joints / double jointed / very flexible? _____

Serious accidents, sports injuries, physical trauma? _____

Have you had a head injury, even one that you consider mild (like falling and hitting your head on the ice)? _____

How would you describe your energy level? _____

Would you say you're under a lot of stress? _____

Do you have any material implants / devices in your body at this time? Examples: joint replacements; spinal stabilizing devices; breast implants; mesh used in hernia repair; dental work including root canals, implants, metal-containing fillings? If so, please list: _____

Have you recently had any metal devices / fillings removed? _____

Have you had any major known chemical, biotoxin, or toxic metal exposures (mold, pesticides, herbicides, mercury, lead, tobacco use, etc)? If so, what and when? _____
_____

Specifically, have you ever lived or worked in a water-damaged building? Water damage may occur for many reasons, even in a dry climate. (Plumbing or roof leaks, etc.) _____

What environment did you grow up in (big city, small town, farm…)? _____

Have you had standard childhood vaccines? _____ HPV vaccine? _____ Shingles? _____Do you get an annual flu shot? _____ Extra vaccines, say for overseas travel or military service? _____

Please say a bit about your food / eating style: _____
_____

Is it common for you to feel tired after you eat? ____

Do you get "hangry" if you go too long between meals? ____

How is your digestion (indigestion, slow or fast transit time)? _____

Have you ever had trouble losing weight and keeping it off? ____

Please briefly describe your physical exercise program / history: _____

When do you typically go to bed? _____ Arise? _____ Would you say you sleep well? _____
Do you have trouble falling asleep? _____ Staying asleep? _____ Do you use an alarm clock? _____

Do you consistently wake feeling refreshed? _____ Are you alert and ready to go within 30 minutes of wake-up? _____

Do you use a CPAP machine? _____

Do you track sleep quality using a sleep tracker or "smart" system? _____ What kind? _____

Are there any other electronic devices connected to WIFI / Bluetooth / Cellular radio wave in your sleeping room (Smart TV / computer / iPad / Kindle / cell phone)? _____

Do you now do, or have you ever done night "shift work"? If so, when and for how long? _____

Would you consider yourself more of an optimist or a realist? _____

Do you feel like you're thriving in life? Or getting by? _____

Do you easily become concerned about things that may go wrong? Is it easy for your mind to go down the "worst case scenario rabbit hole"? _____

Do you tend to ruminate or talk about adverse events from earlier in your life? _____

Is your mother living? ____ If no, at what age did she pass on? ____ Major health challenges _____
_____

Is your father living? ____ If no, at what age did he pass on? ____ Major health challenges _____
_____

Early Years

What do you know about the period between / immediately prior to your conception through birth?

- (Do you think your mother was very stressed during the time she was carrying you?)
- (Did your mother have any previous pregnancies before you? How many? How long before?)
- (Are you aware of any major toxin exposures or illnesses your mother may have had prior to your arrival?)
- (Was your mother's labor induced? C-section? Vacuum suction or forceps delivery?)
-

What do you know about your young childhood / preschool years?

- (Were you breastfed or bottle fed?)
- (Have you been told you were a colicky baby?)
- (Did you receive standard childhood vaccinations?)

Are you aware of having experienced adverse childhood experiences (ACE) including child abuse and family dysfunction prior to the age of 18? It's not necessary to detail your answer here. We're just looking for correlation. _____ FYI: https://www.ncbi.nlm.nih.gov/pubmed/25300735

Learning Style / Accomplishments

Would you say you enjoy learning & exploring new ideas? _____
_____

Would you say you adapt to changes easily, or do you find them more challenging? _____
_____

What are your expectations around how much time you think it could take to achieve the results you desire in our work together? _____

Please briefly share something satisfying or enjoyable that you experienced within the past week: ___
_____

What lifetime accomplishment are you most proud of (in addition to having awesome children, if you are a parent)? _____

What do you feel is the biggest challenge you face in terms of participating in a health-optimizing program? _____

Is there anything else you'd like to share to help me understand your situation? _____
_____

Scope of Practice

I understand that Elizabeth Eckert is a functional nutrition practitioner and not a medical doctor. A functional nutrition practitioner does not diagnose or treat disease. The purpose of this wellness coaching is to optimize health, to explore factors that may interfere with health and vitality, and to explore nutritional and lifestyle factors that may bring greater balance. I understand that I am advised to consult with a medical doctor for all known physical or mental health concerns. I understand that I am advised to maintain a relationship with a primary care provider and consult them for medical concerns that may arise from time to time.

Please sign (parent or guardian if client is under 18 years of age): _____

Date: _____