Armstrong Body Systems

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Patient/Client Health History Form

Maneuver through the form with the TAB key

Personal Information:					
Last Name:		First Name:		DOB:	
Cell Phone		Alt. Phone		Sex:	Select One
Street Address:					
City:	State:	Zip:			
Email:	Height: ft in	Weight:			

Health History: **Health Goal:** ("X" all that apply)		
☐ Cardiovascular	☐ GI/Gut Issues Resolved	☐ Cholesterol
☐ Healthier Lifestyle	☐ Food Sensitivity Test	☐ Inflammation/ Pain Mgmt.
☐ Supplement Accuracy	☐ Blood Sugar/Diabetes	☐ Exercise Rx
☐ Micronutrient Test	☐ Weight loss/Body Composition	
☐ Other:		

Surgeries:	
Date:	Date:
Date:	Date:
Injuries/Limitations:	

Current Prescriptions:			
Name:	Dosage:	Name:	Dosage:
Name:	Dosage:	Name:	Dosage:
Name:	Dosage:	Name:	Dosage:

Current Supplements:			
Name:	Dosage:	Name:	Dosage:
Name:	Dosage:	Name:	Dosage:
Name:	Dosage:	Name:	Dosage:

Menses:	
1st day of last:	Cycle length:
Unusual Points:	

Exercise History:			
Number of Resistance/Weight Training per week: Select One			
Number of Cardiovascular Exercises sessions per week: Select One			
I become out of breath when I exercise: Select One		I stretch my muscles: Select One	
I exercise as a form of stress reduction: Select One			
I was born by C-Section: Select One		I was born vaginally: Select One	

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Lifestyle Considerations: ("X" all that applies)

Sleep: Select One

- ☐ I am sleepy during the day
- ☐ I have trouble falling asleep
- ☐ I have trouble staying asleep

Stress: ("X" all that applies)

- ☐ My daily routine is extremely stressful
- ☐ My daily routine is moderately stressful
- ☐ My daily routine is not particularly stressful
- ☐ I need a stress management routine
- ☐ My stress is ongoing over a long time
- ☐ My stress is short-term
- ☐ I have an effective stress management routine in place

Food/Eating Style: ("X" all that applies)

Breakfast:	Select One
Lunch:	Select One
Dinner:	Select One
Veggies:	Select One
Fruit:	Select One

- ☐ I drink diet drinks or use sugar substitutes
- ☐ I drink soda/energy drinks
- ☐ I drink 3+ alcoholic beverages per week
- ☐ I drink 5+ glasses of wine per week
- ☐ I drink red wine
- ☐ I eat sweet treats7+ times per week
- ☐ I eat rice, pasta or bread 3-6 times per day
- ☐ I eat a low fat diet
- ☐ I eat 3-5 servings of "healthy fat" a day
- ☐ I eat fermented milk products
- ☐ I drink milk
- ☐ I drink soy milk
- ☐ I drink fruit juice
- ☐ I drink 40-100 ounces of water a day
- ☐ I drink 0-36 ounces of water a day

Symptom Survey:

Fatigue	Select One	Headache	Select One	Migraine	Select One
Diarrhea	Select One	Constipation	Select One	Insomnia	Select One
Daytime Tiredness	Select One	Malaise	Select One	Throat clear	Select One
Dark Circles	Select One	Puffy Eyes	Select One	Bloat/gas	Select One
H20 retain	Select One	Muscle/ Joint Pain	Select One	Abdominal pain	Select One
Depressed	Select One	Mood swings	Select One	Memory Issues	Select One
Irritability	Select One	Anxiety	Select One	Attention Difficulties	Select One
Skin rash/Prob's	Select One	Cravings	Select One		

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Testing Results: Please fill in with any **known** test results			
Unknown	I have blood pressure above 120/80	Unknown	I have diabetes or pre-diabetes
Unknown	I have fasting blood sugar of 90 or above	Unknown	I have elevated liver or kidney enzymes
Unknown	I have triglyceride levels above 150	Unknown	I have total cholesterol above 200
Unknown	I have LDL above 100	Unknown	I have HDL below 50
Unknown	My serum Vit D level is 75 or below	Unknown	My resting heart rate is above 75 bpm.
Unknown	My body composition/body fat is above 25%(female) or 20% male		

Body Composition:

Tape Measurements (To be completed by healthcare professional)

	Date	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Chest:									
Arm:									
Waist:									
Hips:									
Thigh:									
Calf:									
Caliper:									
Arm:									
IC:									
Thigh:									
or									
Scapula									
Chest:									
Abdomen									