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PERSONAL HEALTH INVENTORY

NAME____**DATE**__________________

ADDRESS____

CITY, STATE, ZIP, COUNTRY____

HOME PHONE_________________**WORK PHONE**_________________**CELL PHONE**______________________

E-MAIL ADDRESS____

OCCUPATION____**DATE OF BIRTH**_________________

AGE________________________**HEIGHT**_______________________ **WEIGHT**__________________________

ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE? IF SO, LIST ALL CONDITIONS BEING TREATED:

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LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU CURRENTLY TAKE:

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LIST ALL VITAMINS, HERBS OR OTHER SUPPLEMENTS YOU CURRENTLY TAKE:

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(If female) ARE YOU PREGNANT? _____________________**HOW MANY MONTHS?**______________________

HOW MANY BOWEL MOVEMENTS DO YOU HAVE? DAILY______________WEEKLY___________________

WHAT FORM OF EXERCISE DO YOU ENJOY? ____

HOW OFTEN DO YOU EXERCISE (daily, 3 times a week, 2 a week, etc.) ______________________________

HOW LONG DO YOU EXERCISE IN ONE SESSION (15 min, 30 min, etc.) ______________________________

WHAT IS YOUR PRIMARY HEALTH CONCERN? PLEASE DESCRIBE IN DETAIL

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DESCRIBE YOUR DIET (vegan, vegetarian, high protein, high carbohydrate, south beach, raw foods, etc)

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PROVIDE SIGNIFICANT DETAILS OF YOUR DIET (many salads, frequent fried foods, daily protein shakes, skip certain meals, frequent juicing, meat 2-3 times per day, anything unique to you)

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HOW MANY 8 oz GLASSES OF WATER PER DAY? ____

HOW MANY CUPS COFFEE OR REGULAR TEA PER DAY? ____

HOW MANY GLASSES OF ALCOHOLIC BEVERAGES PER DAY? _____________PER WEEK ________________

HOW MANY OUNCES OF SOFT DRINKS PER DAY? ____________DIET OR REGULAR? ___________________

WHICH OF THE FOLLOWING SWEETENERS DO YOU USE?

WHITE SUGAR _____ RAW SUGAR ______ EQUAL ______ SWEET 'N LOW ______ SWEET THING___________

STEVIA ______ XYLITOL ______ MAPLE SYRUP ______ AGAVE SYRUP ______ OTHER ____________________

HOW MUCH INGESTED EACH DAY? ____

HEALTH HISTORY: Have you *ever* been diagnosed with any of the following health problems?

- ☐ Tension Headaches
- ☐ Migraine headaches
- ☐ TMJ Disorder
- ☐ Back Pain or Sciatica
- ☐ Chest Pain or Angina Pain
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Lung or Respiratory Disorder
- ☐ Liver Disease or Hepatitis
- ☐ Urinary or Bladder Infection
- ☐ Kidney Disorder or Kidney Stones
- ☐ Gall Bladder Disorder or Gallstones
- ☐ Spleen or Lymphatic Disorder
- ☐ Gastric or Peptic Ulcer
- ☐ Irritable Bowel Syndrome or Colitis
- ☐ Diabetes Type I
- ☐ Diabetes Type 2 – Onset_______
- ☐ Hypoglycemia
- ☐ Hyper-Thyroid
- ☐ Hypo -Thyroid
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Osteoporosis
- ☐ Tremors
- ☐ Peripheral Neuropathy
- ☐ Shingles (Herpes Zoster)
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Pneumonia
- ☐ Cancer
- ☐ Benign Tumors
- ☐ Blood Disorders
- ☐ Liver Disease
- ☐ Pancreatitis
- ☐ Glandular Disorders
- ☐ Coronary Disorder or Heart Attack
- ☐ Dysmenorrheal
- ☐ Reynaud’s Disease
- ☐ Deafness or Tinnitus
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Seizures or Epilepsy
- ☐ Concussion
- ☐ Cancer or Tumors
- ☐ HIV+ or AIDS
- ☐ Auto-Immune Disorders
- ☐ High Cholesterol
- ☐ Venereal Disease
- ☐ Multiple Sclerosis
- ☐ Polio or Mononucleosis
- ☐ Allergies or Hay Fever
- ☐ Asthma or Bronchitis
- ☐ Tuberculosis
- ☐ Attention Deficit Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Panic Attacks or Phobias
- ☐ Clinical Depression
- ☐ Suicide Attempts
- ☐ Schizophrenia
- ☐ Pre-menstrual Syndrome
- ☐ Prostate or Vaginal Disorder
- ☐ Anorexia or Bulimia
- ☐ Sexual Dysfunction
- ☐ Skin Disorder, Eczema, or Hives
- ☐ Other

EXPLAIN ALL ITEMS CHECKED ____

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INJURIES: Have you ever been injured in any of the following types of accidents? List the specific injury and approximate date it occurred (month & year).

☐ **AUTOMOBILE ACCIDENT - SPECIFIC INJURY ______________________APPROX DATE_________________**

☐ **SPORTS-RELATED INJURY - SPECIFIC INJURY _____________________ APPROX DATE _________________**

☐ **WORK-RELATED INJURY - SPECIFIC INJURY ______________________ APPROX DATE _________________**

☐ **SURGICAL COMPLICATION - SPECIFIC INJURY ____________________ APPROX DATE _________________**

☐ **FALLS - SPECIFIC INJURY _____________________________________ APPROX DATE _________________**

☐ **VICTIM OF CRIME OR ABUSE - SPECIFIC INJURY __________________ APPROX DATE _________________**

☐ **OTHER ACCIDENT OR INJURY - SPECIFIC INJURY __________________APPROX DATE _________________**

EXPLAIN ALL CHECKED ____

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MAJOR SURGERIES AND APPROX YEAR: ____

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ALLERGIES AND TREATMENTS: ____

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CURRENT CONDITIONS: In the *past year* have you noticeably experienced any of the following?

- ☐ Pain in Legs or Feet
- ☐ Pain in Arms, Wrist, Hands
- ☐ Cold Hands or Cold Feet
- ☐ Swollen Ankles or Feet
- ☐ Stiff, Aching Joints
- ☐ Neck or Shoulder Tension
- ☐ Back Pain
- ☐ Grinding Your Teeth
- ☐ Rapid Heart Beat
- ☐ Irregular Heart Beat
- ☐ Abnormal Sweating
- ☐ Excessive Sweating
- ☐ Hyperventilation
- ☐ Dizziness or Fainting
- ☐ Large Weight Gain
- ☐ Large Weight Loss
- ☐ Overeating or Binge Eating
- ☐ Under Eating or Poor Appetite

- ☐ Craving for Sweets or Chocolate
- ☐ PMS
- ☐ Menopause
- ☐ Craving for Drugs or Alcohol
- ☐ Dissatisfaction With Job
- ☐ Bored or Uninterested in Things
- ☐ Loneliness or Lack of Nurturing
- ☐ Sex Life Not Satisfying
- ☐ Financial Worries
- ☐ Too Much Work
- ☐ Too Much Rest
- ☐ Too Much Fun
- ☐ Sinus Congestion
- ☐ Colds. Flu, Chills
- ☐ Sore Throats
- ☐ Nausea or Vomiting
- ☐ Diarrhea

- ☐ Less than 2 BM's per day
- ☐ Blurred /vision
- ☐ Lethargy, Fatigue
- ☐ Acid Reflux
- ☐ Heartburn/Indigestion
- ☐ Frequent Gas
- ☐ Laxative Use
- ☐ Difficulty Sleeping
- ☐ Disturbing Dreams
- ☐ Relationship Problems
- ☐ High Stress Level
- ☐ Emotional Abuse
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Eye Problems
- ☐ Dental Problems
- ☐ Hearing Problems
- ☐ Other

ADDITIONAL DETAILS RELEVANT TO ITEMS CHECKED ABOVE____

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SUBSTANCES OR MEDICATION: In the past 6 months, have you regularly taken any of the following?

- ☐ Any Form of Tobacco
- ☐ 2 or More Cups Coffee per day
- ☐ Beer or Wine
- ☐ Liquor or Mixed Drink
- ☐ Aspirin or Tylenol
- ☐ Prescribed Pain Reliever
- ☐ Recreational Drugs
- ☐ 2 or More Glasses/Cans of Sodas per day
- ☐ 2 or More Glasses/Cups Tea per Day (do not include herbal tea)
- ☐ Sleeping Pills
- ☐ Anti-Anxiety Pills
- ☐ Anti-Depressants
- ☐ Blood Pressure Pills
- ☐ Insulin

WHAT DO YOU CONSIDER TO BE YOUR GREATEST STRENGTH?

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WHAT DO YOU CONSIDER TO BE YOUR GREATEST WEAKNESS?

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WHAT IS YOUR SPIRITUAL OR RELIGIOUS ORIENTATION? (OPTIONAL)

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WHAT BUSINESS OR PERSON REFERRED YOU TO TERESA McCURRY?

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MAY I CONTACT THEM TO THANK THEM FOR THE REFERRAL? (List contact information below)

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After receiving your Credit/Debit Pre-Authorization, your Coaching Agreement, and your 3 Questionnaires, Teresa will create a comprehensive "Personal Health Blueprint" for you which will provide the tools you need to achieve your health improvement objectives. It will also include a variety of resources and handouts to help you develop a healthy lifestyle to utilize for life!