

NATURANNA HEALTH APPRAISAL FORM

Medical History

- ☐ Arthritis
☐ Allergies/hay fever
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Autoimmune disease
☐ Blood pressure problems
☐ Bronchitis
☐ Cancer
☐ Chronic fatigue syndrome
☐ Carpal tunnel syndrome
☐ Cholesterol, elevated
☐ Circulatory problems
☐ Colitis
☐ Dental problems
☐ Depression
☐ Diabetes
☐ Diverticular disease
☐ Drug addiction
☐ Eating disorder
☐ Epilepsy
☐ Emphysema
☐ Eyes, ears, nose, throat problems
☐ Environmental sensitivities
☐ Fibromyalgia
☐ Food intolerance
☐ Gastroesophageal reflux disease
☐ Genetic disorder
☐ Glaucoma
☐ Gout
☐ Heart disease
☐ Infection, chronic
☐ Inflammatory bowel disease
☐ Irritable bowel syndrome
☐ Kidney or bladder disease
☐ Learning disabilities
☐ Liver or gallbladder disease (stones)
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological problems (Parkinson's, paralysis)
☐ Sinus problems
☐ Stroke
☐ Thyroid trouble
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Sexually transmitted disease
☐ Seasonal affective disorder
☐ Skin problems
☐ Tuberculosis
☐ Ulcer
☐ Urinary tract infection
☐ Varicose veins
 Other _____

Medical (Men)

- ☐ Benign prostatic hyperplasia
☐ Prostate cancer

- ☐ Decreased sex drive
☐ Infertility
☐ Sexually transmitted disease
 Other _____

Medical (Women)

- ☐ Menstrual irregularities
☐ Endometriosis
☐ Infertility
☐ Fibrocystic breasts
☐ Fibroids/ovarian cysts
☐ Premenstrual syndrome (PMS)
☐ Breast cancer
☐ Pelvic inflammatory disease
☐ Vaginal infections
☐ Decreased sex drive
☐ Sexually transmitted disease
 Other _____
 Date of last GYN exam _____
 Mammogram ☐ + ☐ -
 PAP ☐ + ☐ -
 Form of birth control _____
 # of children _____
 # of pregnancies _____
☐ C-section _____
 Age of first period _____
 Date - last menstrual cycle _____
 Length of cycle _____ days
 Interval of time between cycles _____ days
 Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
☐ Surgical menopause
☐ Menopause

Family Health History

(Parents and Siblings)

- ☐ Arthritis
☐ Asthma
☐ Alcoholism
☐ Alzheimer's disease
☐ Cancer
☐ Depression
☐ Diabetes
☐ Drug addiction
☐ Eating disorder
☐ Genetic disorder
☐ Glaucoma
☐ Heart disease
☐ Infertility
☐ Learning disabilities
☐ Mental illness
☐ Mental retardation
☐ Migraine headaches
☐ Neurological disorders (Parkinson's, paralysis)
☐ Obesity
☐ Osteoporosis
☐ Stroke
☐ Suicide
 Other _____

Health Habits

- ☐ Tobacco:
 Cigarettes: #/day _____
 Cigars: #/day _____
☐ Alcohol:
 Wine: #glasses/d or wk _____
 Liquor: #ounces/d or wk _____
 Beer: #glasses/d or wk _____
☐ Caffeine:
 Coffee: #6 oz cups/d _____
 Tea: #6 oz cups/d _____
 Soda w/caffeine: #cans/d _____
 Other sources _____
☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
☐ 3-4 days per week
☐ 1-2 days per week
☐ 45 minutes or more duration per workout
☐ 30-45 minutes duration per workout
☐ Less than 30 minutes
☐ Walk - #days/wk _____
☐ Run, jog, other aerobic - #days/wk _____

- ☐ Weight lift - #days/wk _____
☐ Stretch - #days/wk _____
☐ Other _____

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt restriction
☐ Fat restriction
☐ Starch/carbohydrate restriction
☐ The Zone Diet
☐ Total calorie restriction
 Specific food restrictions:
☐ dairy ☐ wheat ☐ eggs
☐ soy ☐ corn ☐ all gluten
 Other _____

Food Frequency

- Number of servings per day:
 Fruits (citrus, melons, etc.) _____
 Dark green or deep yellow/orange vegetables _____
 Grains (unprocessed) _____
 Beans, peas, legumes _____
 Dairy, eggs _____
 Meat, poultry, fish _____

Eating Habits

- ☐ Skip meals - which ones _____
☐ One meal/day
☐ Two meals/day
☐ Three meals/day
☐ Graze (small frequent meals)
☐ Generally eat on the run
☐ Eat constantly whether hungry or not

Current Supplements

- ☐ Multivitamin/mineral
☐ Vitamin C
☐ Vitamin E
☐ EPA/DHA
☐ Evening Primrose/GLA
☐ Calcium, source _____
☐ Magnesium
☐ Zinc
☐ Minerals, describe _____
☐ Friendly flora (acidophilus)
☐ Digestive enzymes
☐ Amino acids
☐ CoQ10
☐ Antioxidants (e.g., lutein, resveratrol, etc.)
☐ Herbs
☐ Homeopathy
☐ Protein shakes
☐ Superfoods (e.g., bee pollen, phytonutrient blends)
☐ Liquid meals (Ensure)
 Others _____

I Would Like To:

- ENERGY - VITALITY
☐ Feel more vital
☐ Have more energy
☐ Have more endurance
☐ Be less tired after lunch
☐ Sleep better
☐ Be free of pain
☐ Get less colds and flu
☐ Get rid of allergies
☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
☐ Stop using laxatives and stool softeners
☐ Improve sex drive
BODY COMPOSITION
☐ Loose weight
☐ Burn more body fat
☐ Be stronger
☐ Have better muscle tone
☐ Be more flexible
STRESS, MENTAL, EMOTIONAL
☐ Learn how to reduce stress
☐ Think more clearly and be more focused
☐ Improve memory
☐ Be less depressed
☐ Be less moody
☐ Be less indecisive
☐ Feel more motivated
LIFE ENRICHMENT
☐ Reduce my risk of degenerative disease
☐ Slow down accelerated aging
☐ Maintain a healthier life longer
☐ Change from a "treating-illness" orientation to creating a wellness lifestyle