Kali WELLNESS

Health History Questionnaire

「 Personal Details 」

Full Name: ____________ Email: ____________ Phone: ____________

Address: ____________ City: ____________ State: ______ Zip: ______

Shipping Address: ____________

*Please list your shipping address for supplement delivery if different from above *(address, city, state, zip)*

Date of Birth: ____________ Blood Type: ____________ Language: ____________

(month / day / year)

Gender:
- Male
- Female
- Unknown

Gender Identity:
- Male
- Female
- Transgender Male
- Transgender Female
- Genderqueer

Race:
- American Indian / Alaska Native
- Native Hawaiian / Pacific Islander
- Asian American
- African American
- White Caucasian

Ethnicity:
- Hispanic / Latino
- Not Hispanic / Latino

Marital Status:
- Single
- Married

Smoking Status:
- Current (Every Day)
- Current (Frequent)
- Former
- Never

Employment Status: Employed | Full-Time Student | Part-Time Student | Unemployed | Retired

Occupation: ____________ Employer: ____________

「 Current Healthcare 」

What other healthcare are you currently receiving? ____________

Primary Care Physician: ____________ Date of last physical exam: ____________

Current Prescription Medications and Doses: Please specify name and dosage

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Current Supplements and Non-Prescription Medications (this includes any pills, liquids, ointments, and suppositories):
Please specify name, brand and dosage of all OTC medications, herbs, vitamins, and homeopathic remedies

Allergies: List any allergies and adverse reactions *(medications, food, tape, latex, chemicals and environmental allergies)*

Current Health Concerns: Please list your most important health concerns *(in priority order)*

1. ____________________ 4. ____________________

2. ____________________ 5. ____________________

3. ____________________ 6. ____________________

What are your top 3 goals while working with us?

1. ____________ 2. ____________ 3. ____________

⌈ Additional Health Questions ⌋

How is your sleep? Excellent Good Poor

How many hours on average do you sleep a night? Less than 5 5 - 6 6 - 7 7 - 8 More than 8

Describe your sleep pattern: Sleep through the night Wake often Wake at same time nightly

What foods do you avoid eating? *(if any)* ____________________

What type of movement or exercise do you partake in and how often? ____________________

If applicable, how would you describe your menstrual cycle? ____________________
Please include frequency, consistency, and any abnormal symptoms

How are your bowel movements? ____________________
Please include frequency, consistency, and any abnormal symptoms

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⌈ Past Health History ⌋

When did you first notice signs of illness? ______

Can you link the start of illness to any events in your life? ______

Age when you last felt well, if ever? ______

Hospitalizations (year/reason): ______

Serious illnesses or injuries (year/cause): ______

History of medical or cosmetic surgeries and injuries requiring stitches (year/cause): ______

Do you have any scars on your body? Yes No *If yes, where?* ______

Please share your dental history: Please include cavities, dental amalgams, root canals, wisdom tooth extractions or cavitation surgery

Do you have a current dental panoramic x-ray? Yes No

How would you describe your health as a child? Good Fair Poor

Childhood Illnesses: Mumps Pertussis Chicken Pox

⌈ Vaccination History ⌋

Did you receive all typical childhood vaccinations? Yes No

List any adult or travel vaccinations (date/type) and any adverse reactions to vaccines (date/vaccine type/reaction):

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⌈ Environmental History ⌋

Where did you grow up? ______________________

Where have you spent the majority of your adult life? ______________________

Have you ever lived abroad? Yes No *If yes, where?* ______________________

Have you ever lived in a home with mold? Yes No

If yes, please share more details: ______________________

Have you ever or do you currently live within a half mile radius of a major highway? Yes No

If yes, please share more details: ______________________

Do you have any known exposures to metals or pesticides? Yes No

If yes, please share more details: ______________________

⌈ Health Journey ⌋

What have been the most helpful tools/therapies on your healing journey to date?

Are there any tools/therapies that you are not comfortable using?

Are there any tools/therapies you are open to or curious about trying?

Where do you feel you might need the most support? Is it physical, mental, emotional or spiritual?

Do you confirm that the above is correct to the best of your knowledge? Yes No

In case the patient is a minor, specify the name of the Guardian of Responsible Party: ______________________

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