LIFESTYLE HEALING
INSTITUTE

Overall Health Assessment

Name _____ Date _____

Street _____ City _____ State _____ Zip _____

Date of Birth _____ Phone Number _____ Email _____

Emergency Contact Name _____ Relationship _____ Phone _____

Diagnosed Diseases/Conditions (i.e. Diabetes, Lyme Disease, Fibromyalgia, Heart Disease, etc.)

Please include the year you were diagnosed as well as the diagnosing physician/professional.

1. _____ Year Diagnosed _____ Who Diagnosed You _____

2. _____ Year Diagnosed _____ Who Diagnosed You _____

3. _____ Year Diagnosed _____ Who Diagnosed You _____

4. _____ Year Diagnosed _____ Who Diagnosed You _____

5. _____ Year Diagnosed _____ Who Diagnosed You _____

Top Symptoms of Concern (i.e. Anxiety, Sleep, Brain Fog, Pain, etc.)

Please rate your symptoms from “0-10” with “10" being the most severe. Please include the year that these symptoms first began.

1. _____ Severity (0-10) _____ Year Symptom Began _____

2. _____ Severity (0-10) _____ Year Symptom Began _____

3. _____ Severity (0-10) _____ Year Symptom Began _____

4. _____ Severity (0-10) _____ Year Symptom Began _____

5. _____ Severity (0-10) _____ Year Symptom Began _____

Allergies to Medications/Food/Environment

1. _____ 3. _____

2. _____ 4. _____

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Current Medications

Please include the reason you are taking each medication as well as the prescribing physician or health practioner.
Please include the approximate year or your age for when for these events occurred.

Name	Strength	Frequency	Duration

Current Supplements

Please include the reason you are taking each supplement as well as when you began taking them.

Name	Strength	Frequency	Duration

Prior Surgeries/Hospitalizations

Please include the type of surgery or reason for your hospitalization.
Please include the approximate year or your age for when for these events occurred.

1. _____ Year _____

2. _____ Year _____

3. _____ Year _____

4. _____ Year _____