Follow Up Health Information Sheet

Name (please print):	Date:	Age:

Considering your overall health, list your biggest complaints:

1.____ When did this start?_______________
2.____ When did this start?_______________
3.____ When did this start?_______________

How many ounces of water do you drink daily?	How many bowel movements do you have a day?

Are your bowel movements: ___loose ___well formed ___sometime loose and sometimes well formed

___incomplete ____dry and hard ___have to take laxatives to go

On a scale from 1 to 10, 10 being the highest level of energy, how much daily energy do you have?

In the night, is it difficult to fall asleep or back to sleep?

Current Height:	Current Weight:	What weight are you most comfortable at?

Emotions: (check predominate emotions)				
___Happy	___Nervous	___Obsessive	___Depressed	___Stuck
___Irritable	___Indecisive	___Withdrawn	___Even Natured	___Angry

Please list all current medications and supplements as well as why you are taking them:

Medication/Supplement	Dosage	Length of Time Taken	Reason

Please list any physical, mental, or emotional changes you have experienced since your previous scan:
____
____
____
____
____

Circle Yes or No: Are you currently pregnant: Yes or No Are you currently breastfeeding: Yes or No

Referring Doctor: ____

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