Daily Habits and Diet

Your Present Lifestyle Habits	Coffee: Cups per Day: Tea: Cups per Day:	Smoking: Packs per Day: Alcohol: No. Drinks per Day:
Daily exercise - level and type (Circle):	None Moderate Heavy	Walking Biking Gym Weightlifting Running Yoga Tennis Other
List any vitamins/supplements you take:		

Have you gained or lost any weight in the past 6-12 months?	Yes No	If Yes, How Much?
Do you have any food allergies?	Yes No	If Yes, Please List:
Do you have any dietary restrictions?	Yes No	If Yes, Please List:
Do you drink sufficient liquids?	Yes No	Specify: Water - Glasses per Day: Sodas - Glasses per Day: Other - Glasses per Day:

Health History (Please Circle)

AIDS/HIV	Cataracts	Hepatitis	Osteoporosis	Suicide Attempt
Alcoholism	Chemical Dependency	Hernia	Pacemaker	Thyroid Problem
Allergies	Chicken Pox	Herniated Disc	Parkinson's Disease	Tonsilitis
Anemia	Depression	Herpes	Pinched Nerve	Tuberculosis
Anorexia	Diabetes	High Cholesterol	Pneumonia	Ulcers
Appendicitis	Emphysema	Kidney Disease	Polio	Tumor / Growths
Arthritis	Epilepsy	Liver Disease	Prostate Problem	Typhoid Fever
Asthma	Fractures	Measles	Prosthesis	Vaginal Infection
Bleeding Disorders	Glaucoma	Migraine / Headaches	Psychiatric Care	Venereal Disease
Breast Lump	Goiter	Miscarriages	Rheumatoid Arthritis	Whooping Cough
Bronchitis	Gonorrhea	Mononucleosis	Rheumatoid Fever	Other:
Bulimia	Gout	Multiple Sclerosis	Scarlet Fever	
Cancer	Heart Disease	Mumps	Stroke	