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WELLNESS & RETREATS

HEALTH HISTORY FORM

FULL NAME:

First name: _____ Last name:_____

ADDRESS:

Street address: _____

City_____ State: _____

Zip code: _____ Country: _____

PHONE NUMBER:

_____ - _____

Area code Phone number

E- Mail:

Preferred contact method: Phone ___ Text: ___ Email: ___

Emergency name and contact number:

Relationship:

Date & place of birth:

Age:

Height:

Weight:

Children and age:

Occupation:

Hours of work/week:

Marital status: Single - Married

HEALTH AND WELLNESS GOALS

What are your health and wellness goals? Why are they important to you

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PERSONAL HEALTH AND FAMILY HISTORY

Health Information

What's the most important thing you'd like to share about your health story?

Do you have any of the following? If so, please list:

- Primary care provider:
- Other physicians or specialists:
- Practitioners, therapists, healers, etc.:

Please list any supplements or medications you take:

Have you experienced any barriers or challenges to accessing healthcare?

Medical Information

Do you have any of the following? If so, please list.

- Medical diagnoses or conditions:
- History of serious illnesses, hospitalizations, injuries, or surgeries:

Family History

Describe the health of your:

- Mother:
- Father:

Is there anything from your childhood pertaining to your health you'd like to share?

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Do you have any other notable family or personal health information you'd like to share?

PHYSICAL HEALTH INFORMATION

Current Weight: Height:

Sleep:

• How many hours do you sleep per night on average?

• How would you describe your quality of sleep?

- How is your energy level most days:

1 2 3 4 5
Very Low Very High

Do you experience any pain, stiffness, or swelling on a regular basis? If so, please explain:

Do you have any of the following concerns? (Check all that apply.)

- Metabolic health:
- Blood Sugar Imbalances:
- Elevated Blood Pressure:
- Elevated Cholesterol:
- Elevated Triglycerides:
- Other:

Digestive health

- Bloating:
- Constipation:
- Diarrhea:
- Nausea:
- Stomach Pain:
- Other:

How many bowel movements (on average) do you have per day?

Reproductive health

- Infertility:
- Irregular Menstrual Cycle:
- Low Libido:
- Other:

Hormonal health

- Thyroid Condition:
- Toxin Exposure:
- Signs or Symptoms of Hormonal Imbalance (please list):

Immune health

- Autoimmune Conditions:
- Low Vitamin D Level:
- Frequent Illness or Infection:
- Allergies and Sensitivities (please list):
- Other:

Brain health

- Brain Fog:
- Difficulty Concentrating:
- Forgetfulness:
- Other:

NUTRITION INFORMATION

What foods did you grow up eating?

How would you describe your past relationship or history with food? Do any specific memories about food or eating come to mind?

Describe your current relationship with food:

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Do you have any food allergies or intolerances? If so, please list:

Do any of the following apply to you? (Check all that apply.)

- Challenges with Preparing Meals:
- Difficulties Chewing or Swallowing:
- Poor Appetite:
- Challenges with Access to Food:

Do you regularly use any of the following? (Check all that apply.)

- Alcohol:
- Tobacco Products:
- Other Substances:

Do you follow a specific eating approach/practice for personal, health, or religious reasons (e.g., vegan, ketogenic, kosher)? If so, please explain:

What does a typical day of eating look like for you? List a few foods/meals and drinks you usually consume in the corresponding categories:

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Breakfast	Lunch
Dinner	Snacks

What, if anything, would you like to change about your nutrition?

MENTAL AND EMOTIONAL HEALTH INFORMATION

How would you describe your overall mental and emotional health?

How do you like to support your mental health?

How do you cope with stress?

Using a 1–5 scale (where 1 = never and 5 = always), rate how often you experience each of the following:

Anger _ Excitement _ Fear _ Joy _
Love _ Sadness _ Stress _ Worry _

SPIRITUAL HEALTH INFORMATION

What role does spirituality play in your life, if any?

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LIFESTYLE INFORMATION

What are the important relationships in your life?

Is there anything you'd like to share about your social life? If so, please explain:

Who do you live with, if anyone?

How many hours per week do you typically work?

What hobbies or recreational activities do you enjoy?

What role does movement, including sports, exercise, and physical activity, play in your life?

ADDITIONAL COMMENTS

Is there anything else you'd like to share?

Date and Signature:

This document "HEALTH HISTORY FORM, needs to be signed and returned to us by mail at: Armelle@cestlaviewellnessretreat.com as soon as possible. Thank you.