HEALTH STATUS ANALYSIS FORM - MEN

Name: ______________________________ Date: __________
Street Address: ______________________________
City: ______________________________ State: ________ Zip: __________
Email Address: ______________________________ Phone: __________
Age ______ Date of birth: ______________ Height ________ Weight ________
Occupation: ______________________________
Please list all persons, including ages, and pets currently living with you: ______________________________
____

What are your current health concerns? Please list in the order of importance to you:
1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

CURRENT HEALTH HISTORY

Name(s) of other health care professionals from which you receive care ______________________________
____
Please list your current and past diagnoses (if any): ______________________________
____
Please list all current medications including dosages: ______________________________
____
List all OTC (over-the-counter medications) you take on a regular basis (3 – 7 days a week): ______________
____
List all of the vitamins, minerals and herbs you take along with the daily dosages: ______________
____
When was the last time you had blood work done? ______________ Do you have a copy? ☐ Yes ☐ No
When was the last time you had your PSA tested? ______________ What were the results? ______________

NUTRITION HEALTH HISTORY

Are there foods you avoid eating? ☐ No ☐ Yes If so, what are they and why? ______________
____
Describe your typical breakfast: ______________________________
Describe your typical lunch: ______________________________
Describe your typical dinner: ______________________________
Describe your typical snack(s): ______________________________
List the foods you crave: ______________________ When do you crave? ______________
Do you now, or have you ever suffered from an eating disorder? ☐ No ☐ Yes If so, explain ______________
____

WEIGHT HISTORY

Are you content with your current weight? ☐ Yes ☐ No If no, what is your ideal weight? ______________
Does your weight fluctuate? ☐ No ☐ Yes If so, give the highest and lowest ______________
What factors do you feel contribute to your changes in weight (age, exercise, nutrition, hormones, etc)? ______________
____

CARDIOVASCULAR HEALTH HISTORY

Do you have any of the following:

High blood pressure: ☐ No ☐ Yes High total cholesterol: ☐ No ☐ Yes High LDL: ☐ No ☐ Yes
High triglycerides: ☐ No ☐ Yes High Chol/HDL Ratio: ☐ No ☐ Yes Low HDL: ☐ No ☐ Yes

SOCIAL, LIFESTYLE & EXERCISE HISTORY

Do you consume alcohol? ☐ No ☐ Yes If so, how many drinks per day? ________________________

Do you consume caffeine? ☐ No ☐ Yes If so, what type _________________ and how much per day _________

Do you smoke/use tobacco? ☐ No ☐ Yes If so, what type ____________________ and how much per day _________

Have you, at any time in your life, lived or worked in an environment that may have exposed you to EXCESSIVE Fluoride (water, drops or treatments), Exhaust Fumes, Lead (paint, paint chips etc), Mercury (paints, pesticides, art supplies, food, etc) Environmental Toxins (benzene, pesticides, molds, formaldehyde) ? ☐ No ☐ Yes

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How many days per week do you exercise? ☐ 3 or more ☐ Less than 3 ☐ Currently not exercising

How much aerobic/cardio exercise do you do per week? ☐ 3 or more ☐ Less than 3 ☐ not exercising
(walking, jogging, biking, swimming, cross-training machine, stationary bike, stair-climber, aerobic dance class, boxing, etc)

How much weight/resistance training do you do? ☐ 3 or more ☐ Less than 3 ☐ Currently not exercising

STRESS AND SLEEP HISTORY

On a scale from 1 – 10 rate your daily energy level? (1 being NO energy – 10 being VERY energetic) ______________

On a scale from 1 – 10 rate your daily stress level? (1 being NO stress – 10 being EXTREMELY stressed) ___________

What is the source of your stress: ☐ Job ☐ Financial ☐ Family/Relationship ☐ Other

How many hours per night do you sleep? _______ What keeps you awake? _______________________________

Do you have problems falling asleep? ☐ No ☐ Yes Do you have problems staying asleep? ☐ No ☐ Yes

GASTROINTESTINAL HEALTH HISTORY

Number of bowel movements per day? _______ If not daily, then how often? ___________________________________

Do you tend towards constipation? ☐ No ☐ Yes Are your stools loose on a regular basis? ☐ No ☐ Yes

Have you had recent changes in your bowel habits? ☐ No ☐ Yes If yes, for how long? _________________________

Are you experiencing any of these symptoms:

Abdominal pain/upset stomach: ☐ No ☐ Yes Gas/bloating: ☐ No ☐ Yes

Heartburn/Reflux: ☐ No ☐ Yes Nausea/vomiting: ☐ No ☐ Yes Hemorrhoids: ☐ No ☐ Yes

Have you had a colonoscopy? ☐ No ☐ Yes If yes, what were the results? ____________________________________

ENDOCRINE HEALTH HISTORY

Do you have any of the following:

Fatigue: ☐ No ☐ Yes Heat or cold intolerance: ☐ No ☐ Yes Low blood sugar: ☐ No ☐ Yes

High blood sugar: ☐ No ☐ Yes Autoimmune disorder: ☐ No ☐ Yes Thyroid condition: ☐ No ☐ Yes

GENETIC HEALTH HISTORY

Please list any serious health conditions your family members have experienced:

Condition:	Family Member	Age of onset/age of death

I understand that Loryn Galardi, M.S. is a clinical nutritionist and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider. I acknowledge that my physician is my primary health care provider, and is responsible for supervising all changes in diet, nutrient intake and exercise. I understand that Loryn Galardi, M.S. will keep therapy notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me. Records will be stored in a secure location. Medical records, personal information and history divulged in session to Loryn Galardi, M.S. will be kept strictly confidential unless I consent to sharing my medical and nutritional information by way of a signed release. I agree to hold Loryn Galardi, M.S. harmless for claims or damages in connection with our work together. This is a contract between myself and Loryn Galardi, M.S., and I understand that it is also a release of potential liability.

The above information is true to the best of my knowledge.

Signed: ____ Date: ______________