

## Elena Bruno Rotolo Client Health History Form

All information is strictly confidential and for informational use only by Elena Bruno Rotolo to assess your wellness state.

### Personal Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Age: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_

Weight six months ago: \_\_\_\_\_

One year ago: \_\_\_\_\_

Would you like your weight to be different: \_\_\_\_\_

If so, what is your goal: \_\_\_\_\_

### Social Information

Relationship status: (S/M/D/W) \_\_\_\_\_

Children: \_\_\_\_\_

Pets: \_\_\_\_\_

Occupation: \_\_\_\_\_

Hours of work per week: \_\_\_\_\_

### Health Information

Please list your main health concerns:

Other concerns and/or goals: \_\_\_\_\_

At what point in your life did you feel best: \_\_\_\_\_  
Any serious illness/ hospitalizations/injuries: \_\_\_\_\_  
How is/was the health of your mother: \_\_\_\_\_  
How is/was the health of your father: \_\_\_\_\_  
What blood type are you: \_\_\_\_\_  
Do you sleep well: \_\_\_\_\_  
How many hours per night: \_\_\_\_\_  
Do you wake up at night: \_\_\_\_\_  
If yes, please explain: \_\_\_\_\_  
Any pain, stiffness or swelling: \_\_\_\_\_  
If so, what part of the body: \_\_\_\_\_  
Constipation/Diarrhea/Gas: \_\_\_\_\_  
Allergies or sensitivities: \_\_\_\_\_  
Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The following 8 questions are for WOMEN only:**

*-Are your periods regular:* \_\_\_\_\_  
*-How many days is your flow:* \_\_\_\_\_  
*-How frequent:* \_\_\_\_\_  
*-Painful or symptomatic:* \_\_\_\_\_  
*-Please explain:* \_\_\_\_\_  
*-Reaching or Approaching Menopause:* \_\_\_\_\_  
*-Birth control history:* \_\_\_\_\_  
*-Do you experience yeast infections or urinary tract infections:* \_\_\_\_\_  
*Please explain:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Information**

Do you take any supplements  
or medications: \_\_\_\_\_  
Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any healers, helpers, pets or therapies with which you are involved:  
Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Food Information**

What foods did you eat most often as a child:

Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_

\_\_\_\_\_

Dinner \_\_\_\_\_ Snacks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Liquids \_\_\_\_\_

\_\_\_\_\_

What foods do you eat most often now:

Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_

\_\_\_\_\_

Dinner \_\_\_\_\_ Snacks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Liquids \_\_\_\_\_

\_\_\_\_\_

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes: \_\_\_\_\_

Do you cook: \_\_\_\_\_

What percentage of your food is home cooked: \_\_\_\_\_

What percentage is not: \_\_\_\_\_

Where do you get the rest from: \_\_\_\_\_

Do you crave sugar, coffee, cigarettes, or have any major addictions: \_\_\_\_\_

The most important thing I should change about my diet to improve my health is: \_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Anything else you would like to share: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_