Personal Health Evaluation

Personal Information

Name:			Date
Address:			Phone
Referred by		Occupation	
Email Address:		Cell phone:	
Age	Sex	Height	Weight

Diet, Nutrition and General Health Practices

Expectations: Are you looking for a "quick fix" or long-term relief or both? Please circle the answer.
How long do you think it will take you to get well?
What is your definition of "Health" or "Wellness"?

How many times do you expect to come to this clinic until you see results?
Are you aware of the Hirai Health work & product guarantee? If not, I will explain.

If you are here for a cleansing program, please indicate if you have had colonics before and if so, when and how many treatments did you do?

Family Medical History (parents, grandparents, siblings or children ever had the following?
Please circle all that apply:
Cancer Diabetes Heart Disease High Blood Pressure Thyroid Disease Mental Health Issues
Seizures Alcoholism Hepatitis Other please list:

Lifestyle: (please circle) married separated divorced other:
Occupation: Type of work; physical desk job combination How many hours per day?
Do you enjoy your work? If no, explain:
Do you commute?

Diet:

a. How often do you consume the following? (1 = Very Frequently; 2 = Often; 3 = Rarely; 4 = Never)
b. Are you on a special diet? Ie. Paleo, Gap, Macrobiotic etc.
c. Do you eat differently when you eat out? Ie. Do not eat meat in restaurants etc.
d. Do you eat non-medicated, hormone free meat? Do you eat fish that is low in mercury?

Refined Sugar:	1	2	3	4	Dairy Products:	1	2	3	4	Fresh Fruits:	1	2	3	4
White Flour:	1	2	3	4	Pork/Shellfish:	1	2	3	4	Vegetables:	1	2	3	4
Alcohol:	1	2	3	4	Red Meat:	1	2	3	4	Green Salads:	1	2	3	4
Fried Foods:	1	2	3	4	Chicken/Turkey:	1	2	3	4	Whole Grains:	1	2	3	4
Caffeine Drinks:	1	2	3	4	Artificial Sweeteners:	1	2	3	4	Fresh Fish:	1	2	3	4
Fermented Foods	1	2	3	4	Ie.Water/milk kefir, kombucha					fermented veges, sauerkraut. etc.				
Quantity of fermented foods/day:					250 mL/500 mL/750 mL/ 1 Litre									

How long have you eaten this way? Have you changed your diet recently?
How long have you been at your current weight?
Have you ever been treated for an eating disorder?

Water:

b. How much water do you drink each day? _____ cups.
What kind of water do you drink?

Sleep:

c. How much sleep do you get each night on average? _____ hours.
How do you sleep? Ie. Do you sleep through the night?
When do you go to bed & when do you get up? Trouble falling asleep or staying asleep?
Dreams? Do you work at night?
Different sleep schedule on weekends/days off?
Disturbed sleep for any reason? Do you use sleep medications? How often?

General habits: (please circle all that apply)
Cigarettes Coffee Black Tea Pop Alcohol
Television: How much T.V. to you watch each day? Each week?
Computer: How much time are you on daily? Video games?
Recreational drugs:

d. How often do you exercise? _____ hours per _____.
What do you do for exercise?

e. What is your energy level like? Do you have an energy dip during the day? If so, when? Are you high energy at night & low in the morning?

f. How often do your bowels eliminate? Can you eliminate with ease?

g. Do you feel like you are under stress? If so, explain.
h. What nutritional supplements are you currently taking? Please list the brand names.

Medical Information

a. What are your current health concerns? Ie. What is your primary health concern you would like help with? Also, list any other health concerns in order of priority.
b. What illnesses & diseases did you have as a child? Does your family history contain any “genetic” diseases or disorders?
c. What kind of family did you grow up in? Did you get along with your family members?
d. What dental work do you have in your mouth? Did any of your symptoms begin after dental work?

e. List any serious illnesses/conditions or surgeries you have had in the past.

f. Are you under a medical doctor's care for your condition? _____
If so, what medications, drugs or therapies are you currently using?

g. What medications, medical procedures, supplements or therapies have you previously tried for your condition? Where any of these supplements or therapies helpful? If so, please note which ones were helpful.

Supplements:
h. Please list the brand names & the name of the natural health supplements that you currently taking or have taken in the last 12 months.

Brand Name: **Supplement Name:**

For Females Only: (circle answers) Age of first menses? Is your period regular? Yes/No
If not, how often do you get it?
Do you have clots/heavy bleeding or hardly bleed at all?
How long do you bleed?
Do you have any symptoms before or after? Please list below.

How many pregnancies/miscarriages have you had?

Do you get break-through bleeding?
Do you use birth control pills or other hormone-based birth control? If so, please list:

Have you had any sexually transmitted diseases in the past?

For Males Only: Do you have trouble peeing or emptying your bladder fully? Yes/No
Do you dribble after you pee? Yes/No
Have you ever had any sexually transmitted diseases? Yes/No
Is it ever painful to pee?
Do you have erectile problems or dysfunction?
Do you or have you been diagnosed with an enlarged prostate gland?

If you are over 50 years of age: Do you have annual PSA screening? Last screening:

i. Additional comments or helpful information, if any.