Greg Gillette, N.E., H.C.
www.gillettenutrition.com
720-369-0177

Name:_____ Date:_____ _____

Weight:_____ Height: _____

Age: _____ Sex: ❑Male ❑Female

Address: _____ _____

City: _____ State: _____ Zip:_____

Email:_____ Phone: _____ _____

Please list your top three health concerns in order of importance:
1.
2.
3.

Please list your top three health/wellness goals:
1.
2.
3.

Please list any nutritional/herbal supplements taken regularly, the dosage, and for what conditions:

Please list any medications taken regularly, the dosage, and for what conditions:

Personal Health Assessment

NAME: _____

Rate each of the following symptoms based upon your typical health profile over the last year.

POINT SCALE
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

	ENERGY/ACTIVITY
	Fatigue, sluggishness
	Apathy, lethargy
	Hyperactivity
	Restlessness
	Easy fatiguability or lack of endurance
	Headaches
	Faintness
	Dizziness
	Insomnia
	Subtotal

	EMOTIONAL/MENTAL
	Mood swings
	Anxiety, fear or nervousness
	Anger or irritability
	Depression
	Poor memory
	Confusion, poor comprehension
	Poor concentration
	Difficulty in making decisions
	Stuttering or stammering
	Slurred speech
	Learning disabilities
	Subtotal

	JOINTS/MUSCLES/SKIN
	Pain or aches in joints
	Stiffness or limitation of movement
	Pain or aches in muscles
	Feeling of weakness or tiredness
	Cramps in legs
	Acne
	Hives, rashes, or dry skin
	Hair loss
	Flushing or hot flashes
	Fingernail abnormalities (spots, ridges)
	Decreased sweating
	Night sweats
	Subtotal

	EARS/MOUTH/THROAT/NOSE/EYES
	Itchy ears
	Earaches, ear infections
	Ringing in ears, hearing loss
	Drainage from ear
	Stuffy nose
	Sinus problems
	Hay fever
	Excessive mucus formation, post-nasal drip
	Sneezing attacks
	Poor night vision
	Watery or itchy eyes
	Swollen, tender or sticky eyelids
	Bags or dark circles under eyes
	Blurred or tunnel vision (does not include near- or far-sightedness)
	Chronic coughing
	Sore throat, hoarseness, loss of voice
	Swollen or discolored tongue, gums, lips
	Canker sores
	Subtotal

	DIGESTIVE TRACT
	Nausea or vomiting
	Diarrhea
	Constipation
	Bloated feeling
	Belching, or passing gas
	Heartburn
	Subtotal

	HEART/LUNGS
	Irregular or skipped heartbeat
	Rapid or pounding heartbeat
	Chest pain
	Chest congestion
	Asthma, bronchitis
	Shortness of breath
	Subtotal

	WEIGHT/OTHER
	Binge eating/drinking
	Craving certain foods
	Excessive weight
	Compulsive eating
	Water retention
	Underweight
	Frequent illness
	Frequent or urgent urination
	Genital itch or discharge
	Injury
	Subtotal

Continued Next Page →

Greg Gillette, N.E., H.C. www.gillettenutrition.com 720-369-0177

Personal Health Assessment, continued

Men's Health	
	Frequent urination
	Difficult urination or dribbling
	Dull ache after urination
	Night time urination
	Benign prostatic hyperplasia
	Decreased sex drive
	Subtotal

Women's Health	
	Yeast infections
	Urinary tract infections
	Frequent urination
	Extended menstrual cycle
	Shortened menstrual cycle
	Pain and cramping during menstrual cycle
	Hot flashes
	Decreased sex drive
	Subtotal

Total Points: _____

Diet Overview

What Do You Usually Eat?

Please list the foods that you typically eat for your meals and snacks. Pease include beverages and other food items, such as mints, gum, etc.

Breakfast Snack Lunch Snack

Dinner Snack Beverages Other