Harvest Health
A Functional Approach to Health

Name/Date_____ Date of Birth_____

Address_____ Phone_____

Occupation_____ Hours per week_____ Height_____ Weight_____

Medical Conditions_____

Medications- Please List Reason Prescribed: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Supplements & Over the Counter Medications: _____ _____

_____ _____ _____ _____

Surgeries & Date of: _____ _____ _____

_____ _____ _____ _____

Allergies or Sensitivities to: _____ Medication _____ Environmental _____Food

Please List: _____

Ethnic Background: _____ Blood Type _____
How is the health of your:
Mother_____ Father_____
Children/Name/Age _____

*Female Only: _____ Menopause _____ Hysterectomy _____ Ovaries Yes No

Periods: _____ Regular _____ Painful/Symptomatic _____ Heavy/Light/Normal

Yeast Infections _____ Yes _____ No - Urinary Tract Infections _____ Yes _____ No

Birth Control _____ Yes _____ No - If so, what/when/how long _____