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PHA – PERSONALIZED HEALTH ASSESSMENT

Your Name:______________________________________ Age:______ Sex: M ◯ F ◯
Address:________________________________ City:______________ State:_____ Zip Code:_______
Telephone:_____________________ Cell:___________________ Email:___________________________
Birth Date:__________ Height:__________ Weight:__________ Waist Size: ______________

Medication(s): If currently taking NO Medications, Please Mark: ◯

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Smoke: Yes ◯ No ◯ Alcohol: Yes ◯ No ◯ Exercise: Yes ◯ No ◯
First date of your last Menstrual Period, if applicable: ________________ Age of Menopause, if applicable: ________
Previous Surgery: Hysterectomy? Yes ◯ No ◯ If yes, date: ____________ Oophorectomy: Yes ◯ No ◯
Allergies? ____
Have you ever been the victim of sexual abuse? Yes ◯ No ◯

Today's Date: _____________, 20____

Doctor's Name: ____________________

Please List 3 Major Symptoms and Brief Description.

1) ________________________________
2) ________________________________
3) ________________________________

Practitioner's Comments

Directions:

- ***Answer the following questions carefully & thoroughly.*** *Place a check mark in the BOX of each sign or symptom you have experienced in the past 3 months.*

General Health

Mild	Moderate	Severe		Mild	Moderate	Severe	
☐	☐	☐	Urinary Incontinence/Infection	☐	☐	☐	Irregular Heartbeat
☐	☐	☐	Anti-Social	☐	☐	☐	Low Blood Sugar
☐	☐	☐	Bone Loss-Osteoporosis	☐	☐	☐	Gas & Bloated Stomach
☐	☐	☐	High Blood Pressure	☐	☐	☐	Loss of Confidence
☐	☐	☐	Unwanted Facial Hair	☐	☐	☐	Increase Thirst & Appetite
☐	☐	☐	Light headed	☐	☐	☐	Sugar Craving
☐	☐	☐	Abnormal Blood Sugar	☐	☐	☐	Craving Salt
☐	☐	☐	Numbness of Feet	☐	☐	☐	Acid Reflux
☐	☐	☐	Severe Acne & Pimples	☐	☐	☐	Capillary Fragility/Bruising
☐	☐	☐	Too Aggressive, Pushy, or Bossy	☐	☐	☐	Hemorrhoids

RESULTS ARE NOT INTENDED TO DIAGNOSE, PREVENT OR TREAT ANY DISEASE OR CONDITION, AND SHOULD BE INTERPRUPTED WITH YOUR HEALTHCARE PROFESSIONAL

Hypothyroid / Adrenal Fatigue

- ☐ ☐ ☐ Anxiety/Nervousness
- ☐ ☐ ☐ Irritable/Moody
- ☐ ☐ ☐ Drowsy/Sleepiness During Day
- ☐ ☐ ☐ Memory Problems
- ☐ ☐ ☐ Severe Headaches/Migraines
- ☐ ☐ ☐ Lack of Libido
- ☐ ☐ ☐ Skin Aging/Thin/Wrinkles
- ☐ ☐ ☐ Water Retention
- ☐ ☐ ☐ Hoarser/Deeper Voice
- ☐ ☐ ☐ Depressed
- ☐ ☐ ☐ Lack of Orgasm
- ☐ ☐ ☐ Mental Fatigue
- ☐ ☐ ☐ Excessive Cold Hands & Feet
- ☐ ☐ ☐ Dry Skin & Dry Hair
- ☐ ☐ ☐ Heart Palpitation
- ☐ ☐ ☐ Sleep Difficulties/Insomnia
- ☐ ☐ ☐ Fuzzy/Cloudy Thinking
- ☐ ☐ ☐ Fat Waist & Hips /Overweight
- ☐ ☐ ☐ Loss of Muscle/Strength
- ☐ ☐ ☐ Increased Fatigue/Tiredness/Lack of Energy
- ☐ ☐ ☐ Bone & Joint Pain/Arthritis
- ☐ ☐ ☐ Carpal Tunnel Syndrome
- ☐ ☐ ☐ Decreased Immunity/Frequent Colds
- ☐ ☐ ☐ Pessimistic
- ☐ ☐ ☐ Stressed
- ☐ ☐ ☐ Muscle Pain/Fibromyalgia
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Unsteady Gait

Hyperthyroid

- ☐ ☐ ☐ Tachycardia – Rapid Heartbeat
- ☐ ☐ ☐ Shakiness - Hands
- ☐ ☐ ☐ Severe Oily Skin
- ☐ ☐ ☐ Unintentional Weight Loss
- ☐ ☐ ☐ Loss of Appetite
- ☐ ☐ ☐ Increased Sweating

Female Only

- ☐ ☐ ☐ Pre-Menstrual Syndrome
- ☐ ☐ ☐ Polycystic Ovaries
- ☐ ☐ ☐ Excessive Menstrual Bleeding
- ☐ ☐ ☐ Vaginal Dryness
- ☐ ☐ ☐ Lack of Menstruation
- ☐ ☐ ☐ Dry Eyes
- ☐ ☐ ☐ Breast Swelling/Tenderness/ Cystic
- ☐ ☐ ☐ Uterine Fibroids
- ☐ ☐ ☐ Sagging Breast
- ☐ ☐ ☐ Menopause
- ☐ ☐ ☐ Hot Flashes
- ☐ ☐ ☐ Night Sweats

Male Only

- ☐ ☐ ☐ Enlarged Man Breast
- ☐ ☐ ☐ Soft Difficult Erection
- ☐ ☐ ☐ Frequency of Urination
- ☐ ☐ ☐ Prostate Enlargement
- ☐ ☐ ☐ Difficulty Urinating

Signature:____ **Date:**__________________________

For Office Use Only

Date Received: ______________________________ **Initial:** __________

Received Via: ☐ **FAX** **EMAIL** **CONFERENCE**

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