This is a preview format:
When you purchase a consultation
a Word version that can be filled-in
and saved will be downloaded for use.

New Voice for Health

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Return to by e-mail to: eval@newvoice.net

(if no response within 48 hours, please follow up with a call)

Health Evaluation

Date: _____
Name: _____
Address: _____
Phone: _____
e-mail: _____
Cell: _____

Age:

Height:

Weight:

General health:

Energy level:

Blood pressure:

Physicians name/location:

Date of last exam:

Known medical conditions:

Surgeries, kind and dates:

Family Medical History:

Diabetes, who:

Heart Disease, who:

Cancer, who and type

Bone Scan:

Date. Results:

Mammogram:

Date, Results:

Hormone Medications:

Brand/Type, dose, time of day taking, date started

Medications Taking:

Brand/Type, dose, time of day taking, date started:

Supplements and Vitamins:

Type, dose per day, time of day

Drug Allergies: (Please list all,)

Diet:

Vegetarian?

Vegan?

Organic sources?

Describe food, and time of day.

Breakfast:

Lunch:

Dinner:

Snacks:

Exercise:

Number of times week:

Kind of exercise:

How long per session:

How many years:

Stress Level: Low, Medium, or High?

Describe type:

How many years:

What stress relief do you use? (exercise, meditation, etc.)

Hormone Symptoms (place an X next to all that apply under each hormone listed. Many of the symptoms are repeated. Please mark each that applies in each hormone section, as symptoms do overlap.)

Type 1 profile:

Hot flashes

Foggy thinking

Memory lapses

Incontinence

Tearful

Depressed

Sleep disturbances

Heart palpations

Bone loss

Dry skin / dry hair

Headaches

Mood swings (PMS)

Water retention

Nervous

Irritable

Anxious

Cold body temperature

Elevated triglycerides

Fibrocystic breast disease

Weight gain at hips

Weight gain at waist

Bleeding changes

Heavy periods

Breast cancer

Low sex drive

Type 2 profile:

Candida infections

Fibrocystic breasts

Hair loss

Anxious

Headaches

Miscarriage

Arthritis

Endometriosis

Bone loss

Easily stressed

Water retention

Sleep disturbances

Weight gain

Heavy periods

Irritable

Irregular periods

Painful menstrual cramps

Break-through bleeding

Fibroids

Mood swings

Hypothyroidism

Type 3 profile:

Low sex drive

Vaginal dryness

Fatigue

Aches/pains/arthritis

Memory lapse

Incontinence

Heart palpitations

Depressed

Sleep disturbances

Thinning of pubic hair

Loss of muscle mass

Thinning skin

Fibromyalgia

Increased facial hair

Increased body hair

Oily skin

Increased acne

Breast cancer

Elevated triglycerides

Ovarian cysts

Hair loss on scalp

Nervous

Irritable

Type 4 profile:

Fatigue

Sugar cravings

Allergies

Chemical sensitivity

Stress

Low blood sugar

Cold body temperature

Irritable

Arthritis

Heart palpations

Aches / pains

Sleep disturbances

Bone loss

Fatigue

Weight gain at waist

Loss of muscle mass

Thinning skin

Breast cancer

Elevated triglycerides

Irritable

Anxious

Memory lapse

Heart palpitations

Headaches

Stress

Cold body temperature

Sugar cravings

Low sex drive

Hair loss

Increased facial hair

Increased body hair

Acne

Nervous

Type 5 profile:

Cold body temperature

Cold hands and feet

Fatigue

Depressed / sad

Weight gain

Cannot lose weight

Forgetful

High cholesterol

Poor concentration

Mood swings

Puffy eyes / face

Low blood pressure

Slow pulse rate

Decreased sweating

Dry or brittle hair

Hair loss

Nail brittle / break easily

Aches / pains

Low sex drive

Heart palpations

Sleep disturbances

Bone loss

Loss of muscle mass

Type 6 profile:

Painful indigestion

Bloating

Gas

Feeling of undigested food

Headache

Pain / tenderness under right side of ribcage

Light-colored stool

Diarrhea or

Constipation and

Frequent need to use laxatives

Dental history:

Do you have any silver / mercury amalgam fillings in your teeth?

If so, how many?

How long have you had them?

Have you had any removed?

How long ago did you have them removed?

Did you do any toxin clearing after removing them?

If yes, what did you use and for how long?

Vaccination history:

List recent vaccinations with dates:

Have you had flu vaccinations?

When?

Living environment:

Power lines in close proximity?

Cell tower in close proximity?

Smart Meters:

Electric?

When installed?

Gas?

When installed?

Water?

When installed?

Cell phone use – how many hours per day?

Computer use – how many hours per day?

Cordless phones? How many?

Do you have wireless (WiFi) in:

Work environment?

Home:

Computers/printers?

Television system?

Heater/air conditioner thermostat?

Appliances?

Water source:

Plastic bottles?

Filtered?

Brand of filter?

What are your goals regarding your health, hormone therapy, and any changes you would like to make.

What major concerns do you have?

What would you like me to know?

Those who are still menstruating, please fill out below.

Menstrual Periods:

Regular / irregular?

Describe cycle, days and amount of flow:

Bleeding between periods:

PMS patients only: Symptoms, days of cycle start, and stop

Please check all those that apply:

Nervous tension

Mood swings

Irritability

Anxiety

Weight gain

Water retention

Breast tenderness

Bloating

Headache

Cravings

Heart palpations

Fatigue

Depression

Forgetfulness

Crying

Insomnia