INCREDIBLE HEALTH
HEALTHY AND STRONG

Name: _____ Date of Birth: _____

Review of Medical History and Health Goals

1. List of past medical problems:
   _____
   _____
   _____
   _____
2. List of past major surgeries:
   _____
   _____
3. List of current medications with dose and schedule:
   _____
   _____
   _____
4. Do you have any true allergic reactions to any medications? YES (please list) NO
   _____
   _____
5. Do you have undesired side effects from medications you take or have taken? YES (please list) NO
   _____
   _____
   _____
6. List of all vitamins and supplements with brand:
   _____
   _____
   _____

Lifestyle Review

1. How can Incredible Health help you best? What else would you like to focus on?
   _____
   _____

_____
_____

2. Why do you think you are having this struggle?

_____
_____
_____
_____
_____

3. Describe any issues you have with sleep.

_____
_____
_____

4. Within the last week, what did you do to manage your stress?

_____
_____
_____

5. Do you follow an “eating style”? (Intermittent Fasting, Keto, Gluten Free, etc) YES NO

_____
_____

6. What did you eat before 12N yesterday?

_____
_____

7. What did you eat from 12N to 6PM yesterday?

_____
_____
_____

8. What did you eat after 6PM yesterday?

_____
_____
_____

9. Within the last 7 days, what have you done for exercise?

_____
_____
_____

10. What else do you feel that Dr. Harrison should know?

_____
_____
_____
_____
_____