The Callard Clinic
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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: ◯

_____

_____

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 ◯

Please List 3 Major Symptoms That You Would Like Help With:

1) _____
2) _____
3) _____

Doctors Name:

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

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**

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