



Wholeness and Healing

Support for the Body, Mind and Spirit

Name _____ Age _____

Address _____

Telephone _____ Email _____

Reason(s) for visit: (Please list in order of importance)

Nutrition

Please indicate how many you eat PER WEEK:

_____ Meat _____ Raw Vegetables _____ Fresh Fruit _____ Fermented Foods

_____ Eggs _____ Dairy _____ Alcohol _____ Fast Food

What do you crave? _____

Which foods do you dislike the most? Why? _____

Do you use artificial sweeteners? _____ How much? _____

Do you eat breakfast? If so, what? _____

Hydration

How many ounces of water do you drink in a day? _____ What kind? _____

Do you drink other beverages? If so, what? _____

Timing

What's the first thing you do when you get up in the mornings? _____

What time do you eat your first meal? _____ Last meal? _____

What is your biggest meal of the day? What would it consist of? _____



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Movement

Do you participate in a fun, sweaty activity? If so, what? _____

How often? _____ Do you look forward to it? _____

How do you feel when you're done? _____

Sleep

What time do you wake up? _____ Go to bed? _____

Do you wake up during the night? If so, why? What time? _____

Do you feel rested when you wake up in the mornings? _____

Do you have pain when you wake up? If so, where? _____

Does it get better when you move around? _____

Females

Are you post-menopausal? If yes, at what age did you enter menopause? _____

What were the characteristics of your menopausal experience? _____

Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? _____

Are you now, or in the near future, planning to become pregnant? _____

Is your menstrual cycle regular? _____ How many days in the cycle? _____

Does the flow last longer or shorter than 5 days? _____

Do you have cramps or clotting? _____ Would you describe the color of your menses as more

red, more purple, or more brown? _____

Do you experience PMS, cyclical headaches, or cravings? _____



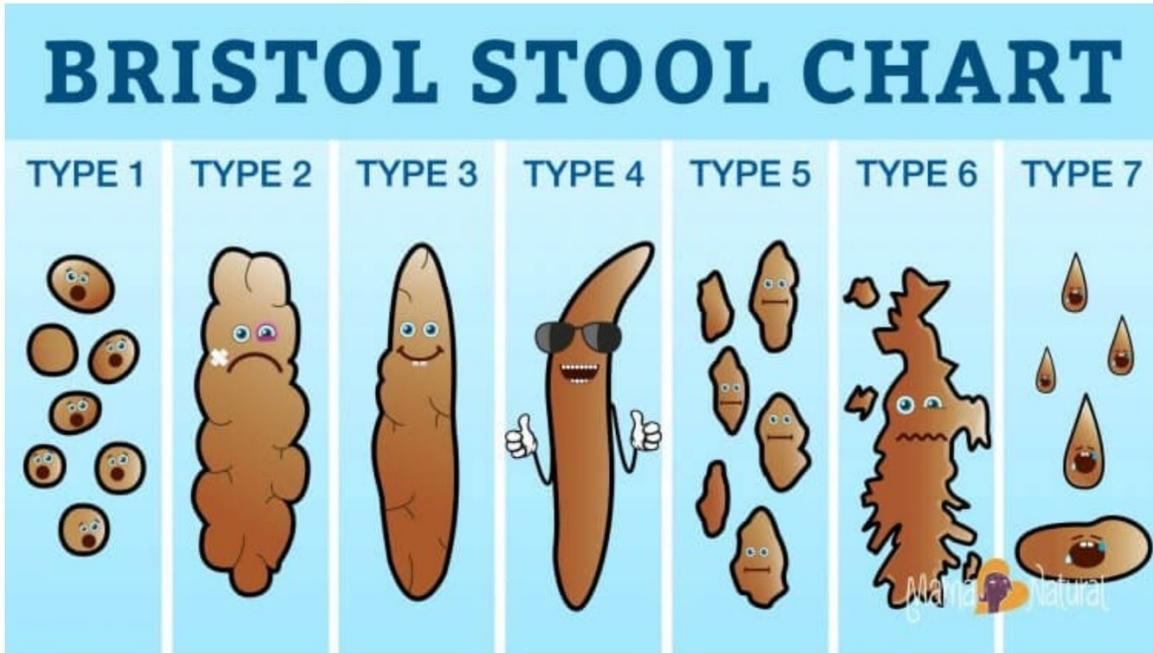
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Elimination

How often do you have bowel movements? _____ Color? _____

Describe your elimination pattern _____



Which number best describes your typical bowel movement? _____ Color? _____

Supplements/medications

Do you take any supplements? If so, what, how often and why? _____

Do you take any OTC medications routinely (such as Aleve or Aspirin)? If so what and how often? _____

Do you take prescription medications (prescribed by a licensed medical professional?) If so what and how often? _____



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Medical history

Have you had any surgeries? If so, what and when? _____

Have you received any diagnoses from licensed medical professionals? If so, what and when?

Naturopathic history

Have you ever been in consultation with a naturopath? If so, why? How long ago?

What was suggested? _____

Did you experience a good outcome? _____

What did you like about it? _____

What wasn't as successful for you? _____

Do you have regular adjustments with a chiropractor? _____

Do you have regular body work/massages? _____

Please check all with which you are familiar:

Homeopathy Bach Flowers/Flower Essences Probiotics

Aromatherapy Muscle Response Testing Herbals Enzymes

I understand that I am here to learn about nutrition and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature _____ Date _____