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Date: ____________

I'm so excited you are taking the initiative to improve your health so you can feel amazing and bursting with energy! The information below will assist me in treating you safely. All of your answers will be held strictly confidential, and your written permission will be required to release any of the information.

First Name: ___________________________ Last Name: ____

Age: ___ Sex: ___ Height:____ Weight: _____ Occupation:_______________________________________

Address: ________________________________ City: _______________ Postal Code: _______________

Home/Cell Phone: ________________________ Business Phone: __________________________________

Email: _____________________________ How did you find me? ___________________________________

Would you like to receive my newsletter that contains healthy recipes and holistic tips? ❑ yes ❑ no

Reason for Visit and Top 3 Health Concerns

____
____
____
____
____
____
____
____

Lifestyle

Rate your energy levels on a scale of 1-10

1 2 3 4 5 6 7 8 9 10

Does you energy fluctuation throughout the day? ____

How many hours of sleep (including naps) do you get per day? _________________________________

What time do you go to bed and when do you wake up? _________________________________

Is it different on weekends? ____________________________________

Do you have trouble falling asleep or staying asleep? ___________________________________

Do you wake feeling rested? ____

Do you enjoy your job? ____

How many hours do you spend front of computer? ______________________________________

Hours on the phone ________________ Hours sitting ____________________________________

What are your hobbies? ____

How many hours do you spend watching TV? ____

Do you exercise (frequency, type, duration)? ____

Do you take vacations? ____

Medical History

How would you describe your general state of health? (select one)

Excellent **Good** **Fair** **Poor**

Are you currently taking any medications? If so please list them ___________________________________

____

____

____

Have you ever taken birth control, antibiotics or any medication for an extended period of time or frequently? ____

____

____

Are you currently taking nutritional supplements? _______________________________________

____

____

____

Do you have any allergies or sensitivities? ____

____

____

____

Do you have any fillings (number and type)? ____

____

____

Have you been diagnosed with a disease or illness? ______________________________________

____

____

____

Have you been hospitalized or undergone surgery (gallbladder, appendix, tonsils)? _______________

____

____

____

How many bowel movements do you have each day? _____________________________________

Family History

Is there a history of disease in your family? ____

____

____

____

Females

Are you or could you be pregnant? ____

Are you pre/post menopause or have there been changes to your flow? ______________________

Do you experience PMS or menopausal symptoms? _________________________________

____

Diet

How many glasses of water do you drink per day? _______________________________

Do you share your meals with family/partner? __________________________________

Do you feel that there are restrictions to your diet due to other people's preferences? __________

Do you follow a specific diet (v, gf, veg, paleo, etc.)?______________________________

Are there any foods you avoid, why? ____

____

What foods do you crave the most? ____

What is your typical Breakfast ____

Lunch ____

Dinner ____

Snack ____

Do you experience any symptoms immediately after meals? ___________________________

____

Chemicals / Environmental

Do you smoke? How many a day? ____

Do you drink alcohol? How frequently? ______________________________________

Do you do recreational dugs? ____

Have you ever been treated for drug/alcohol dependency? ____________________________

Emotional

Have you experienced trauma or loss in past? ___________________________________

Please rate your stress level on a scale of 1 – 10

1 2 3 4 5 6 7 8 9 10

What is the primary cause of your stress? _____________________________________

____

How does your stress manifest? ____

____

What is your coping mechanism for stress? _____________________________________

____

Anything Else?

Is there anything else you would like to share with me that hasn't been covered? ____________

____

____

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