

Name: _____ Age: _____

Address: _____

Telephone (best): _____ Email: _____

Reason for visit (prioritized):

1. _____
2. _____
3. _____

Nutritional data:

How many ounces of water/day? _____ What kind? _____

What other beverages and how much?

Do you use artificial sweeteners? _____ If so, which ones? _____

How often and in what?

Do you eat breakfast? _____ If so, what? _____

How much of the following do you consume? example: 1D = 1/day, 2W = 2/week, 3M = 3/month)

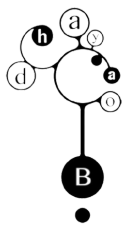
Fruits _____ Vegetables _____ Eggs _____ Dairy _____ Fermented food _____ Fast food _____

Chicken _____ Fish _____ Red Meat _____ Pork _____ Meat Alternatives _____

What do you crave?

What foods do you dislike the most?

Why?



Timing:

What is the first thing you do when you get up in the morning?

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

Which meal is your largest of the day?

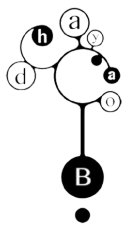
Describe a typical largest meal.

Movement:

Do you exercise/move/participate in fun sweaty activity? If so, what and how often?

Do you look forward to it?

How do you feel when you are finished?



Sleep:

What time do you go to bed? _____ How long do you sleep? _____

Do you wake often? _____

If so, why and what time(s)?

Do you feel rested when you wake up for the day?

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

Does it go away upon moving?

Eliminations:

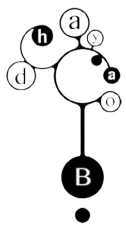
Do you have daily bowel eliminations? _____ If yes, how many per day? _____

If no, please describe your elimination pattern.

Please indicate the most descriptive number(s) of your elimination(s) using the Bristol Stool chart provided. BSC # _____ Color _____

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? _____ Longer than 28 days? _____ Shorter?

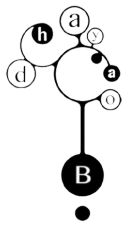
Is your flow longer or shorter than 5 days?

Do you have cramps or clotting? _____ Would you describe the color of your menses as bright red, dark purple, or brown?

Do you experience PMS, cyclical headaches, or cravings?

Supplements/medications:

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



Do you take any OTC medications routinely (such pain reliever or allergy medicine)? If so, what and how often?

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

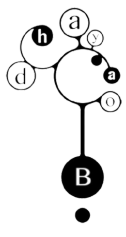
Medical history:

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 remedies
- Probiotics
- Aromatherapy
- Muscle response testing
- Herbals
- Sports Nutrition
- Enzymes

Disclaimer:

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