Natural Health Assessment

Date

First Name _____ Middle Initial ____ Last Name_____
Preferred nickname_____

Address Line 1
_____
Address Line 2
_____
City _____ State _____ Zip Code _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____
Cell Phone (_____) _____-_____
Email _____
Date of Birth _____/_____/_____ Sex: Male Female Non-binary
Marital Status: Single Married Other
Employment Status: Employed Unemployed FT Student PT Student Other_____

Spouse information
First Name _____ Middle Initial _____ Last Name
_____
Home Phone (_____) ____-_____ Work Phone (_____) _____-_____

Employer information
Name
_____
Your Occupation _____ Your Job Description _____
Address
_____
City _____ State _____ Zip Code _____

Emergency
Contact_____
Relationship to Patient _____
Contact Home Phone (_____) _____-_____Cell Phone (_____) ____-_____

How did you hear about Ripple Natural Health?
_____

Goals/concerns/complaints (put in order of severity—#1 most severe) and how long has it been a concern/complaint? How often? Does it interfere with activities of daily living?

1._____

2._____

3._____

Nutritional data:
How many ounces of water per 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)
Fruit _____ 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?
_____
_____
_____

Sleep:
What time do you go to bed? _____ How long do you sleep? _____
Do you wake up often?
_____
If so, why and at what time(s)?
_____
Do you feel rested when you wake up for the day?
_____

Stress
What are some stress factors in your present life?_____
_____
_____
On a scale from 1 (lowest) to 10 (highest) would you rate your stress level _____-

Rate current status of health:

Excellent _____ Good _____ Fair_____ Poor_____

Do you take any supplements/herbs? _____ If so, what, dosage, why, and how long_____
_____
Do you take any OTC medications (such as pain relievers or allergy medicine)? If so, what, dosage, why, and how long?
_____
_____
Do you take prescription medications (prescribed by a licensed medical professional?) If so, what, dosage, why and how long?
_____
_____

List Allergies (drugs, foods, animals, plants, etc.)
_____

Medical history:
Have you had any surgeries, traumas, injuries, hospitalizations? 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 successful for you?

_____

What other Alternative treatments have you tried?

_____

Your response to the treatments?

_____

____Bell's Palsy _____Bites or stings _____Bladder _____Blood Pressure-High _____Blood Pressure -Low _____Blood Sugar - Low _____Blood Sugar - High _____Body Odor _____Boils _____Bones Concerns _____Breathing trouble _____Bronchitis _____Bruises _____Burns _____Cancer _____Candida _____Canker Sores _____Carpal Tunnel _____Cataracts _____Chest Congestion _____Chest Pain _____Cholesterol _____Circulation _____Cold - Common _____Cold - Temperature _____Colic _____Constipation _____Cough _____Dandruff _____Depression _____Diabetes _____Diarrhea _____Difficulty swallowing _____Digestion _____Dizzy _____Ear Infection _____Ear Ringing _____Edema _____Emphysema _____Epilepsy _____Eyesight _____Fainting _____Fatigue _____Fever _____Flu _____Gallstones _____Gas _____Gout _____Gums _____Hair Issues _____Headache _____Heart Issues _____Heartburn _____Hemorrhoids _____Herpes _____Hives _____Hormones _____Hyperthyroidism _____Hypothyroidism _____Hypoglycemia _____Impotence _____Incontinence _____Indigestion _____Insomnia _____Kidney Pain _____Kidney Stones _____Laryngitis _____Leukemia _____Liver _____Lump in throat _____Lung Issues _____Lupus _____Lymph Glands _____Memory _____Menopause _____Menstrual Cramps _____Migraines _____Mononucleosis _____Motivation _____Mucous _____Muscle Aches _____Nails _____Nausea _____Nervousness _____Nose Bleeds _____Pain, Muscles _____Pain, Joints _____Pain, nerves _____Pain, organ _____Pain, unspecified _____Parasites _____Parkinson's disease _____Perspiration _____PMS _____Pneumonia _____Polyps _____Pregnancy _____Prostate _____Psoriasis _____Rash _____Reproductive _____Respiratory _____Rheumatism _____Ring Worm _____Seizures _____Shingles _____Shortness of breath _____Sigh or yawn often _____Sinus issues _____Skin Issues _____Sleep _____Snoring _____Sore Throat _____Stomach _____Stress _____Stroke _____Teething _____Tonsillitis _____Tumors _____Ulcers _____Urinary Infections _____Varicose Veins _____Vertigo _____Vision _____Weight -Overweight _____Weight -Underweight _____Yeast Infections

____Other please specify_____

_____

Family History—Age, Health-Heart disease, cancer, diabetes, etc

Grandparents_____

Mother_____

Father_____

Siblings_____

Missed Appointment/ Cancellation Policy Clarification

- Cancellation after 24 hour notice will be expected to pay a $50 fee for missed appointment

Print Name:_____

Sign and date _____

I understand that I am here to learn about food choices, lifestyle, and natural health practices, and that I will be offered information about food, nutritional supplements, herbs, and homeopathy, based on sound scientifically supported study. I have come of my own free will and acknowledge that Caroline Pace will offer assessments based on formal training in natural health and holistic ministry.

I fully understand that those who counsel me are not medical doctors, and I am not here for medical diagnoses 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 matters intended for the maintenance of the best possible state of natural health and stewardship of the body, and do not involve the diagnosing, treatment, or prescribing of remedies for disease.

*Signature*_____ *Date* _____