Client Information

Name: Age:

Address:

Cell phone: Email:

Occupation:

How many hours per day: Stress level of your work:

Check all boxes that apply to you most:

☐ Spiritual ☐ Religious ☐ Agnostic

☐ Gardening ☐ Reading ☐ Journaling ☐ Meditation/Prayer ☐ Self Reflection

Relationship Status: ☐ Single ☐ Married ☐ In a relationship ☐ It's complicated

What gender do you identify as: ☐ Female ☐ Male ☐ Non-binary ☐ Other

Have you recently experienced any significant life changes:

Reason for visit (in order of importance):

How much water do you drink: What type of water:

What other beverages:

Do you drink coffee/tea or caffeinated beverages:

What is your sweetener of choice: Servings per day:

What is your typical breakfast:

What is your typical lunch:

What is your typical dinner:

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

Raw vegetables: Cooked vegetables: Frozen fruit: Fresh fruits:

Fast food: Meat: Eggs: Dairy: Alcohol:

What foods do you crave?

What foods do you dislike the most?

Why?

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Client Information

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

What time do you eat your first meal? What time do you eat your last meal?

Which meal is the largest of the day?

Describe a typical largest meal?

Do you exercise? If so, what and how often?

Do you look forward to it? How do you feel when finished?

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?

List any surgeries:

Have you received any diagnoses? If so, what and when?

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 or dislike about it?

What wasn't as successful for you?

Do you have regular adjustments with a chiropractor?

Do you have regular body work/massages or Reiki/Energy work?

Please check all which you are familiar:

- ☐ Muscle Response Testing
- ☐ Bach Flowers/flower remedies
- ☐ Homeopathy
- ☐ Probiotics
- ☐ Aromatherapy
- ☐ Herbal Remedies
- ☐ Sports Nutrition
- ☐ Enzymes

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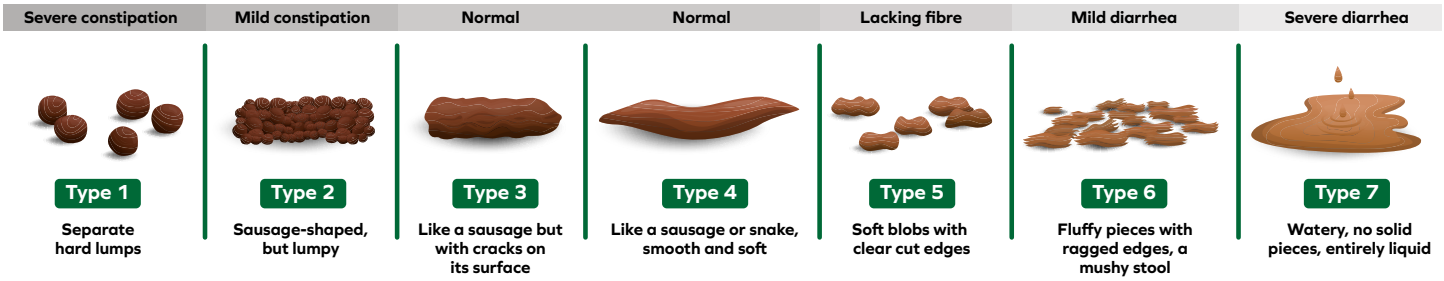
Do you have daily bowel elimination? If yes, how many per day?

If no, please describe your elimination pattern

Please indicate the most descriptive number of our elimination using The Bristol Stool Scale Below:

Bristol Stool Chart Type# Color:

Bristol Stool Chart



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

Do you take an OTC medications routinely (such as 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?

Are you pre or 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?

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I understand that I am here to learn about wellness and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health and that 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 purpose 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 holistic health 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*

When finished, please save your file and email it to: **Orders@HeartSpaceApothecary.com**