

Name _____ **Age** _____

Address _____

Telephone (best) _____ **Email** _____

Reason for visit (prioritized):

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 the 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 up often? _____ If so, why and at 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 movements? _____ 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? _____

Have you had a partial or full hysterectomy? _____ Do you have ovaries? _____

What were the characteristics of your menopausal experience? _____

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

Are you pregnant or 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 (such as pain relievers or allergy medicine)? _____

If so, what and how often? _____

Do you take any medications prescribed by a licensed medical professional)? _____

If so, what, how often, and what condition(s)? _____

Any known drug contraindications (i.e. grapefruit interference with your medications)? _____

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 seen a naturopath or functional medicine doctor? _____

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 bodywork/massages? _____

Please check all with which you are familiar:

____ RBTI Testing

____ Homeopathy

____ Foundations or Pillars of Health

____ Muscle Response Testing

____ Biofeedback Testing

____ Bach Flowers/flower remedies

____ Probiotics/Acids/Enzymes

____ Herbals

____ Supplements

I may be offered information on foundations of holistic and natural health as well as mental and emotional support as a guide to general good health. I understand I may receive information on nutrition supplements and more which is not intended to be a medical diagnosis or treatment. I am not on this or any subsequent visit as an agent for federal, state, or local agencies, or on a mission of entrapment or investigation. The services performed here are always restricted to consultation on nutritional and wellbeing 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 Today _____

****Please note we request your personal medical information to ensure the most effective suggestions. If you opt out of disclosing this information, the practitioner in this consultation cannot be held responsible for any interactions or complications resulting from herb/medicine interactions.***

Please initial here _____ if you decline to provide medical, pharmaceutical, or over-the-counter information.

Consultation Notes:

Bach Flower Key Emotions (Please describe how you're feeling about your life and health right now. You may include background information, such as past trauma or other concerns.):