Dr. Amy Wilson - Board-Certified Doctor of Natural Medicine
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FOUNDATIONAL HEALTH ASSESSMENT

Name _____ Age _____
Address _____
Telephone (Best) _____ Email _____

Reason(s) for visit (prioritized):

1. _____
2. _____
3. _____

On a scale of 1-10 how would you rate your motivation to get to the root cause of why you don't feel well?

1 2 3 4 5 6 7 8 9 10

How willing are you to make lifestyle changes to improve your health and negate contributing toxic factors?

1 2 3 4 5 6 7 8 9 10

Nutritional Data:

How many ounces of water/day? _____ Current weight: _____ lbs.
What kind? (bottled, distilled, R/O, etc..) _____
What other beverages and how much? _____
Do you use artificial sweeteners? _____ If so, which ones? _____
How often and in what? _____
How often do you eat out per week? _____

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

Fruit _____ Vegetables _____ Eggs _____ Dairy _____
Fermented Food _____ Chicken _____ Fish _____ Red Meat _____
Pork _____ Fast Food _____ Meat Alternatives _____ Sugar _____
Raw Nuts + Seeds _____ Alcoholic Beverages _____ Caffeinated Beverages _____
Cigarettes _____

Quality of Food: (circle one) ORGANIC CONVENTIONAL CLEAN 15 – DIRTY DOZEN

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List the three worst foods you eat during the average week:

_____ _____ _____

List the three healthiest meals you eat during your average week:

_____ _____ _____

Describe a typical day of what you eat-

Breakfast: _____
Lunch: _____
Dinner:
_____

What do you crave? (sugar, salt, carbs, etc.)
_____
What foods do you dislike 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 your 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? _____ Why or why not? _____
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? _____

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

Stress:
Rate your stress level on a scale of 1 – 10 during the average week: _____
Describe your line of work: _____
Rate your work stress level on a scale of 1 – 10 _____
What are your work hours? _____

Females:

Are you post-menopausal? _____ If yes, what age did you enter menopause? _____
What were the characteristics of your menopausal experience? _____
_____
Do you currently use Hormone Replacement (HRT) or Hormone-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 experience cramps or clotting? _____
Describe the color of your menses- (bright red, dark purple, brown) _____
Do you experience PMS, cyclical headaches, or cravings? _____
_____

Do you currently have or have breast implants in the past? Y/N
What kind? Saline Silicone
Do you currently receive Botox or any other cosmetic injections? Y/N
If so, what kind? _____

Supplements/Medications:
(you can use the extra sheet for more room to list supplements if needed)

How many rounds of antibiotics have you had in your lifetime? _____ This year? _____

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Do you take any supplements? _____
If so what, how often, and why? _____
_____
Do you take any OTC medications routinely? (pain reliever, 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? _____
_____
Please list any known allergies:
_____

PLEASE REMEMBER TO BRING ALL CURRENT SUPPLEMENTS AND MEDICATIONS TO YOUR APPOINTMENT!

Medical History:

Have you received any diagnoses from licensed medical professionals? _____
If so, what, and when?

Have you ever received any genetic testing? (MTHFR, BRCA, etc.) Y / N
If, yes – please specify:

Describe any personal traumas (domestic abuse, sexual assault, etc.), hospitalizations, surgeries, or familial disease patterns you're aware of:

_____
_____
_____

Does anyone in your family experience similar symptoms to yours? _____
Have you or a family member been diagnosed with chronic fatigue, fibromyalgia, or multiple chemical sensitivities? Y N
If so, please explain: _____
Do you or your immediate family have a history of cancer? Y N
Have you ever been diagnosed with bipolar disorder, schizophrenia, or depression? Y N
Do you have a history of strokes? Y N

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*****IF YOU HAVE ANY RECENT LAB WORK – PLEASE EMAIL IT TO ME PRIOR TO YOUR FIRST APPOINTMENT!***

COVID-19 + Vaccines:

- Have you had COVID? Y N

If so, has your health deteriorated since having COVID? Y N

- Have you had vaccines or been vaccinated for COVID-19 in the last 30/60/90 days? Y N

(please circle which applies)

- Are you experiencing persistent health complications and difficulty recovering post COVID? (feel like you're a "long-hauler") Y N

Please share anything else from your medical history that you feel may be helpful or relevant:
_____
_____
_____

Naturopathic History:

Have you ever consulted with a Naturopath? _____
If so, date, and reason? _____
_____
_____
What was suggested? _____
Did you experience a good outcome? _____

Naturopathic History (cont.):

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? _____

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Please check all with which you are familiar:

◊ Herbs
◊ Bach Flowers/Flower Essence Remedies
◊ Iridology
◊ Homeopathy
◊ Essential Oils- Aromatherapy
◊ pH Balancing- RBTI Testing
◊ Muscle Response Testing
◊ Foundational Health
◊ Nutrition
◊ Probiotics
◊ Enzymes
◊ TCM-Traditional Chinese Medicine

Disclosure Agreement

I understand that I am here to learn about nutrition, holistic healing, and better health practices, that I will be offered information about foundational health, nutrition + supplements, herbs, and various natural healing remedies and modalities to use as a guide to general good health. This is a personal ministry and the services offered are based on holistic, naturopathic, and alternative health theories of counseling mind-body-spirit.

I fully understand that those who counsel me are not medical doctors, and I am not here for medical diagnostic purposes or treatment procedures. To "doctor" natural medicine is no more than "to teach" natural healing remedies and modalities. I am not on this visit, or any subsequent visit, an agent for federal, state, or local agencies on a mission of entrapment or investigation.
The nature of the services to be provided are not licensed by the State of California per Business and Professions Code section 2053.6., and are based on foundational health, naturopathic, and alternative recommendations, and are at all times restricted to consultation on nutritional matters and utilization of natural health remedies and modalities intended for the maintenance of the best possible natural health states and stimulation of inherent healing; it does not involve diagnosis, treatments or prescribing of remedies for disease.

Signature _____ Date_____

**Please note that we cannot legally require disclosure of your personal medical information.*
I request it to make 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.

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BRISTOL STOOL CHART

TYPE 1		**Separate hard lumps** VERY CONSTIPATED
TYPE 2		**Lumpy and sausage like** SLIGHTLY CONSTIPATED
TYPE 3		**A sausage shape with cracks in the surface** NORMAL
TYPE 4		**Like a smooth, soft sausage or snake** NORMAL
TYPE 5		**Soft blobs with clear-cut edges** LACKING FIBER
TYPE 6		**Mushy consistency with ragged edges** INFLAMMATION
TYPE 7		**Liquid consistency with no solid pieces** INFLAMMATION AND DIARRHEA

MEDICALNEWSTODAY

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