



Amy Wilson  
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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? \_\_\_\_\_

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

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



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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

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





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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.*

## BRISTOL STOOL CHART

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



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