**Natural Body Balance**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (Street, City, State, Zip)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_

Marital Status: (circle one) Single Married Divorced Widowed

Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years in Occupation\_\_\_\_\_\_

Do You Enjoy Your Job? Y / N …if No,Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Significant Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What brings you in today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the onset of symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specific events at onset? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Main Health Goals & Expectations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you get each night? \_\_\_\_\_\_\_\_\_ How many hours needed? \_\_\_\_\_\_\_\_\_\_

Do you feel like you get quality & quantity of sleep needed?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours exercise/sweaty activities weekly?\_\_\_\_\_\_\_ What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you sit per day (work or school)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How manyounces of water daily? \_\_\_\_\_\_\_\_\_\_What type? Filtered Distilled RO Tap Spring

How many bowel movements daily\_\_\_\_\_\_\_Consistency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tendency toward: constipation / diarrhea / Normalcy (circle one)

Females: Date of Last Period\_\_\_\_\_\_\_\_\_\_\_\_ How many days\_\_\_\_\_ Cramps Y/N Heavy Bleeding Y/N

Are you on Birth Control Y/N If yes how many years\_\_\_\_\_ What Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant Y/N If yes how many weeks \_\_\_\_\_\_ Are You Nursing Y/N

Are you trying to get pregnant Y/N How long have you been trying to conceive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many meals daily eaten? \_\_\_\_\_\_\_\_ Circle- if Breakfast Lunch Dinner Snack\_\_\_\_\_\_\_\_

Do you follow a specific diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you cut certain things from your diet? If Yes, Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much of the following do you consume? (example, 1D=once daily, 1W= weekly, 3M=3 monthly)

Soda \_\_\_\_\_\_\_\_\_\_\_ Alcoholic Bev\_\_\_\_\_\_ Smoking\_\_\_\_\_\_\_\_\_\_ Coffee/Caffeine\_\_\_\_\_\_\_\_\_\_\_

Fast Food\_\_\_\_\_\_\_ Fried Foods\_\_\_\_\_\_\_ White Flour\_\_\_\_\_\_\_ Sugar usage\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Milk\_\_\_\_\_\_\_\_\_\_\_\_\_ Dairy\_\_\_\_\_\_\_\_\_\_\_\_\_ Sugary Foods\_\_\_\_\_\_ Processed Foods\_\_\_\_\_\_\_\_\_\_

Fruits\_\_\_\_\_\_\_\_\_\_\_ Veggies\_\_\_\_\_\_\_\_\_\_ Eggs\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grains\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meat\_\_\_\_\_\_\_\_\_\_\_\_ Fish\_\_\_\_\_\_\_\_\_\_\_\_ Beans\_\_\_\_\_\_\_\_\_\_\_\_\_ Organic Foods\_\_\_\_\_\_\_\_\_\_\_\_

What types of food do you crave? Salty Chocolate Sweets Breads Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your favorite foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much daily energy do you have? 0 1 2 3 4 5 6 7 8 9 10

How many hours of TV do you watch? Daily\_\_\_\_\_\_\_\_\_\_\_ Weekly \_\_\_\_\_\_\_\_\_\_

How many hours a week do you spend with: Family\_\_\_\_\_\_\_\_\_\_\_\_ Friends \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do you spend for? Rest\_\_\_\_\_\_ Relaxation\_\_\_\_\_\_ Recreation \_\_\_\_\_\_\_

How Many Minutes or Hours do you Spend in? Sunlight\_\_\_\_\_\_\_Fresh Air\_\_\_\_\_\_\_ In Nature\_\_\_\_\_\_

Do you do breathing exercises daily or at all?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_ Recent changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications including Prescription & over the counter along with daily doses

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List past and present illnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have you been diagnosed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

Have you had any major illness, injuries, falls, auto accidents, or surgeries? Women, please include information about childbirth (include dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |  |  |
| --- | --- | --- | --- |
| Date | Procedure | Physician | Notes (Practitioners use only) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Current/Recent Physicians\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last year, what conditions have you been treated by a physician for?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have you tried to get relief that did or did not work for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate below where you are experiencing concerns.**

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Place an “X” on the line below to indicate the level of the problem.

(No Symptoms) 1————————————————————————————————10 (Extreme Symptoms)

**Current Supplements:**

Do you take supplements daily 1x / 2x day / 3x day, or most days / or just occasionally?

Food/Digestive Enzymes with each meal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitamins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minerals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Probiotics \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Omegas, Essential Fatty Acids, Fish Oils \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fiber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Antioxidants \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List other vitamins, herbs, or homeopathics you use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check the following conditions that apply to you, PAST & PRESENT. Add comments for clarification as needed.**

|  |  |  |
| --- | --- | --- |
| **Musculoskeletal**□ Headaches□ Joint Stiffness/Swelling□ Spasms/Cramps□ Strains/Sprains□ Neck Pain□ Upper/Mid Back Pain□ Low Back Pain□ Shoulder, Neck, Arm, Hand Pain□ Hip, Leg, Foot Pain□ Chest/Rib Pain□ Numbness/Weakness□ Problems Walking□ Jaw Pain/TMJD□ Tendonitis□ Bursitis□ Arthritis□ Osteoporosis□ Scoliosis□ Bone or Joint Disease□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Circulatory/Respiratory**□ Dizziness□ Shortness of Breath□ Fainting□ Cold Hands/Feet□ Cold Sweats□ Chills□ Swollen Ankles□ Difficulty Lying Flat□ Pressure Sores□ Varicose Veins□ Blood Clots□ Heart Conditions/Chest Pain□ Palpitations□ Allergies□ Sinus Problems□ Asthma□ Cough□ Coughing Blood□ Wheezing□ Excessive Bleeding□ Pace Maker□ Lymphedema□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Skin**□ Rashes□ Itching/Burning□ Hives□ Eczema□ Athlete’s Foot□ Warts□ Moles□ Acne□ Cosmetic Surgery□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Gastrointestinal**□ Gum Bleeding□ Nervous Stomach□ Indigestion□ Heartburn/Reflux□ Nausea/Vomiting□ Change in Bowel Patterns/IBS□ Constipation□ Diarrhea□ Jaundice□ Abdominal Pain□ Gall Bladder Problems/Removal□ Diverticulitis□ Crohn’s Disease□ Colitis□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Nervous/Eyes/ENT**□ Numbness/Tingling□ Loss of Strength/Weakness□ Paralysis□ Twitching□ Chronic Pain□ Sleep Disorders□ Ulcers□ Herpes/Shingles□ Cerebral Palsy□ Epilepsy/Seizures□ Chronic Fatigue Syndrome□ Multiple Sclerosis□ Muscular Dystrophy□ Parkinson’s Disease□ Difficulty Hearing□ Ringing in the Ears□ Eye Correction□ Double Vision□ Cataracts□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Reproductive/Urinary**□ Burning on Urination□ Nighttime Urination□ Blood in Urine□ Erectile Dysfunction□ Prostate Problems□ Abnormal Discharge□ Yeast Infection□ Bladder Leakage□ Pregnancy□ Current □ Previous□ PMS□ Menopause□ Pelvic Inflammatory Disease□ Endometriosis□ Hysterectomy□ Fertility Concerns□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Other**□ Loss of Appetite□ Forgetfulness/Memory Loss□ Confusion□ Depression□ Anxiety□ Weight Loss/Weight Gain□ Fatigue□ Fever□ Loss of Hair□ Hot/Cold Intolerance□ Difficulty Concentrating□ Hearing Impaired□ Visually Impaired□ Eating Disorder□ Diabetes□ Fibromyalgia□ Post/Polio Syndrome□ Cancer□ Rheumatoid Arthritis□ Infectious Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Congenital/Acquired Disabilities**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****History of Abuse / Treatment:** Check all that apply* H/O Alcohol Addiction/Treatment
* H/O Drug or Elicit/Recreational Drug Abuse
* H/O Drug or Elicit/Recreational Drug Treatment
* Are you currently on ADD/ADHD Meds
 |

**Childhood History:**

Condition of Your Mother’s Health While Pregnant With You \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were You Born: C-Section / Naturally Breastfed: Y / N If Yes How Many Months \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were You Fully Immunized as a Child Y / N Were You Sick Often As a Child Y / N

Were You A Colicky Baby Y / N Were You Constipated as a Child Y / N

How Many Rounds of Antibiotics Would You Say You Had As a Child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle Any of The Following & List How Many Times:

Colds \_\_\_\_\_\_ Strep Throat\_\_\_\_\_\_ Bronchitis\_\_\_\_\_\_ Ear Infections \_\_\_\_\_\_\_ Ear Tubes \_\_\_\_\_\_\_ Rashes\_\_\_\_\_\_

Circle Any of The Following That You’ve Ever Had, Fill in Any Not Listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma Chicken Pox Shingles Measles Mumps Scarlet Fever Seizures Whooping Cough

**Family History:**

Are you adopted? \_\_\_\_

Is your father alive? If yes, how old\_\_\_\_\_ If no, what was the cause of death and age at death?\_\_\_\_\_\_

Is your mother alive? If yes, how old\_\_\_\_ If no, what was the cause of death and age at death?\_\_\_\_\_\_

Write “F” for father, “M” for Mother, “S” for sibling:

\_\_\_\_\_Heart Disease \_\_\_\_\_Lung Disease \_\_\_\_\_\_Liver Disease \_\_\_\_\_Kidney Disease \_\_\_\_\_Cancer

\_\_\_\_\_Stroke \_\_\_\_\_Diabetes \_\_\_\_\_Asthma \_\_\_\_\_Arthritis \_\_\_\_\_ Headaches \_\_\_\_\_Chronic Pain

\_\_\_\_\_Mental Illness \_\_\_\_\_Trouble Sleeping \_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stress:**

Please list any current/recent physical or emotional stressors that have caused anxiety in your life:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you cope with stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any significant stresses/traumas (physical or emotional), including the approximate date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Which emotions are the hardest for you to deal with (with yourself and/or with others)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a daily practice of self-care? (Journaling, meditation, prayer, deep breathing, stretching)? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 how ready/willing are you to make lifestyle changes to improve your health?\_\_\_\_\_\_

What things have you already changed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there certain things you are NOT willing to change?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled outside of the USA Y /N If Yes, When \_\_\_\_\_\_\_\_\_\_\_\_\_ Work / Pleasure / Volunteer

Did Any of These Trips Require Any Vaccinations To Travel Y / N If Yes What Vaccines?\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find out about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food, homeopathics, nutritionals, essential oils, and therapies as a guide to general good health. The sessions will be consulting to educate and empower clients to take an active participation for their own health. The goal is to gain a greater knowledge in relation to your health choices & is not intended to be interpreted as a substitute for a licensed physician’s treatment.

I fully understand that Laura Hegewald of Natural Body Balance LLC is not a medical doctor and I am not here for medical diagnostic purposes or treatment procedures.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**