**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) |
|  |  |  |  |
|  |  |  |  |
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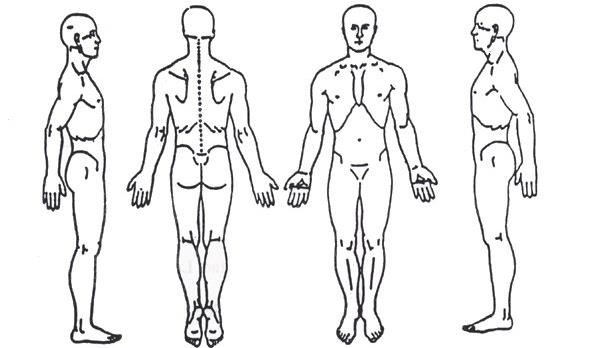
Current/Recent Physicians\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**