**CLIENT INFORMATION**

**Today's Date**:

**Full Name**:

**Date of Birth**:

**Gender**:

**Email**:

**Phone #**:

**Full Postal Address**:

**Profession/Occupation**:

**Height**:

**Weight**:

**Relationship Status**: Married Single Divorced Widowed

**Children**? No Yes, how many _____ For females any miscarriages? No Yes, how many ___

**Contact Details of GP/Primary Health Care Physician's Address and Phone Number**:

_____

**Do you give consent for me to contact your GP, if necessary**? Yes No

**Check Box indicating vaccine received and write year received, if possible**:

| | | | |
|---|---|---|---|
| | MMR (Measles, Mumps, Rubella) | | Polio |
| | Tdap (tetanus, diptheria, pertussis) | | Influenza (list years taken) |
| | HPV (Human papillomavirus) | | Chickenpox (Varicella) |
| | Meningococcal | | Covid (please provide # doses & brand taken) |
| | Pneumococcal | | Small pox |
| | Dengue | | Shingles |
| | Hepatitis A | | Rabies |
| | Hepatitis B | | Rotavirus |
| | | | Other: |

**Use this space to add any additional information regarding reactions to any vaccine**:

_____

_____

_____

_____

**Family medical history (parents & grandparents on both sides including cause and age of death). Please indicate also where there may be a history of alcoholism, drug addiction, behavioral problems, birth defects, disabilities or any other unusual condition or imbalance such as allergies, hay fever, asthma, etc.:**

**Current OTC medications, doctor prescriptions (this is very important so it can be researched to understand the impact on nutrients and side effects) and supplements taking include Brand name (to ensure any supplement that may be prescribed will not be contra-indicated).:**

**Personal medical history & any past surgeries (list all major diseases, accidents, hospitalizations, medical treatments and traumas in CHRONOLOGICAL order). Please list childhood diseases, dental work, etc. This is very important as it can help look at the vital connections between current health and past history. Any body parts removed such as gallbladder, appendix, etc.:**

**Allergies: list all allergies, past and/or present (such as any medications, hay fever, cats, etc.) If so, do you take any medications to alleviate these allergies when they occur?**

**Are you having any other treatment for the above condition(s)?**

**Have you received any other 'alternative' treatments for any previous health issues that have helped in the past?**

**What is the main reason you are seeking care?**

**What are your health goals?**

**How often do you get a fever? When was your last high fever (above 101.3)? What were the symptoms at the time?**

**How often do you experience a common cold? Does the cold resolve on its own or does it go into secondary infections?**

**Do you suffer from any skin issues or had skin issues in the past?**

**Have you ever suffered from a concussion or other type of head injury? If so, how long ago?**

**How would you describe your personality and how would others describe you?**

**Have you ever used homeopathic remedies in the past? If so, which remedy and for what symptom:**

Please take your time to pause and reflect when answering the following questions/symptoms below. Every question has a purpose; you DO NOT need to remember every detail. Once the form is received, it will be thoroughly looked through and patterns may be seen. Although there are sections of the body being addressed on the questions below, holistic well-being is not 'sectioned'. All the information given will be integrated into your session to get a more in-depth case history. You may notice some connections as you fill in the form. You may notice your symptoms started following a medical procedure or an emotional event. This form is just as much to allow you to reflect back on your health journey as well as to gather information so the best support can be provided.

**Circle the symptoms that apply to each category.**

**CARDIOVASCULAR**: fatigue, numbness of hand/feet, noises in head or ringing in ear, drowsy, palpitations, sigh frequently/air hunger, increased need for fresh air, swollen ankle(s) worse at night tendency to anemia, smoker, shortness of breath, swelling of legs and ankles, light-headedness, loss of consciousness, little or no joy in life, experiencing loss, experiencing rejection, obesity high C-reactive protein, little or no exercise, chest pain, fatigue/pain in arms/legs, feeling unloved, feeling impatient, feeling rejected, none of the above

**BONES and MINERALS**: hip and joint pain, receding gums and/or dental cavities, tendency towards slouching, bone loss/osteoporosis, crunching or creaking joints, none of the above

**DIGESTION**: lower bowel gas several hours after eating, burning stomach sensation relieved by eating, alternating diarrhea/constipation, indigestion, difficult bowel movements, ulcers/colitis/gastritis/IBS, bloating, bad breath, coated tongue, rectal itching, inability to gain weight, international travel, cramping, excessive belching/burping, none of the above

**LIVER and GALLBLADDER**: pain under right side of rib cage, frequent skin rashes, bitter metallic taste in the morning, bowel movements painful or difficult, low energy/weakness/exhaustion, upset from greasy/fatty foods, frequent headaches, pain between shoulder blades, general feeling of poor health, aching muscles, feeling of nausea, frequent use of laxatives, history of gallbladder issues, history of hepatitis, history of jaundice, sneezing attacks, itchy skin that is worse at night, stools light colored, none of the above

**THYROID**: insomnia, decreased appetite, increased appetite without gaining weight, trouble gaining weight, increase in weight, highly emotional, night sweats/shakes, inward trembling, eyelids and/or face twitch, can't work under pressure, nervousness, intolerance to heat, flush easily, thin/moist skin, dry/scaly skin, heart palpitation, pulse fast at rest, slow pulse (below 65), irritable and restless, ringing in ear, impaired hearing, mental sluggishness, headaches upon rising that wear off during the day, increased frequency of urination, fatigue easily, sleepy during the day, constipation, hair coarse/falls out, reduced initiative, none of the above

**ENVIRONMENT**: exposure to fumes (ex: paint, salon, car), skin disorders (ex: psoriasis, hives), live near power lines/mobile masts, mercury fillings (silver ones), use of household chemicals, use pesticides, loss of hair, PC work, none of the above

**PITUITARY**: increased/decreased sugar tolerance, low blood pressure, headaches, failing memory, increased sex drive, reduced sex drive, bloating of abdomen, weight gain around hips or waist, tendency to ulcers, menstrual disorders, lack of menstruation, none of the above

**ADRENALS**: dizziness, hot flushes, hair growth on face/body (female), masculine features (female), sugar in urine not diabetes, headaches, increased blood pressure, low blood pressure, chronic fatigue, weakness, exhaustion, respiratory disorders, poor circulation, swollen ankles, bowel disorder, allergies, asthma, brown spots or bronzing skin, crave salt, arthritic tendencies, nails weak/rigid, none of the above

**IMMUNITY**: child with chronic immune disturbances, enlarged glands, skin irritation/eczema, chronic/acute stress overload, swollen lymph glands, re-current minor infections, throat infections, poor wound healing, slow recovery from illness, boils/styes, cold/flu frequently, bumpy skin on arms, inflamed or bleeding gums, cough with mucus, swollen tongue, dark areas under eyes, sore throat, postnasal drip, ear aches and infections, herpes/cold sores, none of the above.

**RESPIRATORY SYSTEM**: allergies, wheezing, shortness of breath, smoking, grief/sadness/crying/recent loss, chest pain, asthma, chronic cough, excessive mucous, cold/flu, skin issues, none of the above

**FILTERING SYSTEM**: water retention, gout, fatigue, dizziness, high blood pressure, low blood pressure, fear, feeling insecure, frequent urination, difficult urination, incomplete emptying of bladder, frequent kidney/bladder infections, painful urination, difficulty starting the stream, weakness of the knee, legs nervous at night (involuntary movement), poor memory, lower back pain, kidney stone/problems, spinal arthritis, ringing in ears, low sex drive, blood in urine, none of the above

**FEMALE**: long standing depression, low feelings before menstruation, headache before or during menses, menopausal hot flashes, pre-menstrual tension, painful breasts, too frequent menstruation, migraine headache, obsessive dietary habits, vaginal discharge, uterine fibroids/cysts, retaining fluid during/before period, unable to trust anyone, unfulfilling occupation, carrying undesirable responsibilities, overwhelmed, lack of fulfilling relationship, diminished sex drive, lack of femininity, painful menses, very easily fatigued, acne worse at menses, menses scanty or misses, periods excessive/long, vaginal dryness, hysterectomy, breasts cysts/lumps/mastitis, miscarriage, frequent thrush, feeling inadequate, feeling unloved, difficulty conceiving, stress from abortions(s), feelings of guilt, feeling rejected, loss of control, lack of romance, feeling put down

**Any further information about your hormones, please explain below:**

_____

_____

_____

_____

**MALE**: Tire too easily, prostate disorder, urination difficult or dripping, avoid activity, pains on inside of legs or heels, leg nervous at night (involuntary), overwhelmed, financial stress, unfulfilling occupation, diminished sex drive, lack of energy, migraine headache, incomplete bowel movement, frequent night urination, depression, job stress, feeling inadequate, loss of control, none of the above

**What type of activities do you do to move your body and elevate your heart rate?**

**FOOD DIARY**

Please write down all the foods and drinks you consume over an average 2-day period. Include everything you consume from the moment you wake to the moment you fall asleep.

Day 1:

Day 2:

**Are there any foods that you would find difficult to 'cut out' of your lifestyle?**

_____

_____

_____

_____

**How many portions of fruit do you eat a day?** 0 1-2 3-5 More than 5

**How many portions of vegetables do you eat a day?** 0 1-2 3-5 More than 5

**How much water do you drink a day?** <17oz 17oz 17-34oz 34-68 oz More than 68oz

**Do you smoke?** Yes No

**How many alcoholic drinks do you drink per week?** 0 1-2 3-4 5 or more I don't drink alcohol

**Is there any additional information you would like to provide?**

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_____

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_____

**Do you confirm you have requested Nutritional Medicine and/or coaching support through Leanne Wasilewski via the New School of Nutritional Medicine?** Yes No

**FORM OF CONSENT TO TREATMENT**: I confirm that I request Nutritional and/or Coaching advice from the New School of Nutritional Medicine. I understand that Leanne Wasilewski is a current student and will get support through the New School of Nutritional Medicine where/when appropriate pertaining to my case.

_____

Signature Today's Date