NATURALLY NOA

Because real health starts from within

Full name: ______________________________

Address:

____

Email address: _______________________________________

Cell: _________________________

Age: ____________Height:________________Date of Birth:______________Place of Birth:_____________

Current weight:_______________Weight six months ago:_______________ One year ago:_____________

Would you like your weight to be different? __________ If so, what? _________

Relationship status: _________

Children: ________ Pets: __________Grandchildren:__________________

Occupation/ main recreational activity : ____

Hours of work per week: __________________

Do you have a strong community of friends and/or family around? __________

Please list your main health concerns:

____

____

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Other concerns and/or goals?____

____

What is your stress level 1-10 (1 very low stress 10 very high stress) __________

At what point in your life did you feel best____________________________________

Any serious illnesses/hospitalizations/injuries?

____

Childhood Vaccines? Y/N_____ Which ones?

____

____

Vaccines as an adult Y/N_______Which ones? ________________________

COVID vaccine? Y/N_________ How many? ________ Date of the last one__________

Flu vaccine? Y/N______________ Date of the last one_________________

Amalgam fillers? Y/N _______Root Canal? Y/N____

Women only IUD/ Birth control pills? _______ How long?______

Implants? Y/N C Sectional? Y/N

Exposure to environmental toxins? Y/N. Circle the ones that apply- scented candles, perfume, commercial laundry, detergent, house cleaning products, mold, radiation, electronic devices, other ____

Did you receive antibiotics at some point in your life? Y/N When? ______________________

How is/was the health of your mother?

____

How is/was the health of your father?

____

What is your ancestry?

____

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Do you sleep well? ___________How many hours? ________ do you wake up at night?

_____Why?____

Any pain, stiffness or swelling _______________________________________

Constipation/Diarrhea/Gas? Please explain:

____

Allergies or sensitivities? Please explain:

____

Do you take any supplements or medications? Please list:

____

____

Any healers, helpers, or therapies with which you are involved? Please list:

____

____

What role does sports and exercise play in your life?

____

What foods did you eat often as a child?

Breakfast____

Lunch____

Dinner____

Snacks____

Liquids____

What's your food like these days?

Breakfast____

Lunch____

Dinner____

Snacks____

Liquids____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

____

What percentage of your food is home-cooked? _____Do you cook ___

Where do you get the rest from?

____

Do you crave sugar, coffee, cigarettes, or have any major addictions?

____

How much water do you drink per day________________

How many times a day do you poop?_________ Solid / liquid?__________

Easy stool Yes/No? ______

Do you follow a certain diet or restrictions?

____

What time you finish dinner? ___________

What time do you go to sleep? _________

The most important thing I should change about my diet to improve my health is:

____

____

Anything else you want to share? ____

____

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