Intake Data

Name ____ **Age** ______
Address
____
Telephone (best) ___________________ **Email** _________________________________

Reason for visit (prioritized):

1. ____
2. ____
3. ____

Nutritional data:
How many ounces of water/day? _______ What kind? ______________________
What other beverages and how much? ______________________________
Do you use artificial sweeteners? _______ If so, which ones? ______________
How often and in what? ______________________________________
Do you eat breakfast? _______ If so, what? ______________________________

How much of the following do you consume? (example: 1D = 1/day, 2W = 2/week, 3M = 3/month)
Fresh fruit _________ Raw vegetables _________ Fermented foods _________
Fast foods _________ Meat _________ Eggs _________ Dairy _________
What do you crave? ____
What foods do you dislike the 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 a 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? ____
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 at what time(s)? ____
Do you feel rested when you wake up for the day? ___________________________________
Do you have pain when you first get up? __________ If so, where? ________________________
____
Does it 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 ______________________________________

Females:
Are you post-menopausal? ________ If yes, at what age did you enter menopause? _________
What were the characteristics of your menopausal experience? ___________________________
____
Do you currently use Hormone Replacement (HRT) or Hormonally-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 have cramps or clotting? ________ Would you describe the color of your menses as bright red, dark purple, or brown? ____
Do you experience PMS, cyclical headaches, or cravings? _________________________________

Supplements/medications:
Do you take any supplements? ________ If so, what, how often and why? _________________
____
____
Do you take any OTC medications routinely (such pain reliver or allergy medicine)? If so, what and how often? ____

Do you take prescription medications (prescribed by a licensed medical professional?) If so, what and how often? ____
____

Medical history:
Have you had any surgeries? If so, what and when? ____________________________________
____
Have you received any diagnoses from licensed medical professionals? If so, what and when? ____
____

Naturopathic history:
Have you ever been in consultation with a naturopath? If so, why? How long ago? ___________ __
What was suggested? ____
Did you experience a good outcome? ____
What did you like about it? ____
What wasn't as successful for you? ____
Do you have regular adjustments with a chiropractor? __________________________________
Do you have regular body work/massages? ____

Please check all with which you are familiar:

- € Homeopathy
- € Bach Flowers/flower remedies
- € Probiotics
- € Aromatherapy
- € Muscle response testing
- € Herbals
- € Sports nutrition
- € Enzymes

I understand that I am here to learn about nutrition and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature ____Date ____________________

Bach Flower Consultation:

RBTI Numbers:

Total Carbs	pH	Total Salts	Cell Debris	Ureas	Total Ureas

Eye Findings:

Face Findings:

Tongue Findings:

Nail Findings:

Active MRT Points:

Recommendations:

Next consultation recommended on: