HEALTH & WELLNESS REMEDIES

Individual Health Information Sheet

Name _____Cell Phone_____

Address_____

City_____State/Zip_____

E-Mail_____

Relief From what top 3 symptoms_____

When did this start? _____ _____

What kind of work do you do?_____

How many hours a week do you work?_____

How many ounces of water do you drink daily?_____What type?_____

Which meals daily eaten? Breakfast Lunch Dinner

How many eliminations per day?_____Solid or Loose? Circle

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

Soda_____ Coffee_____Fast food _____Milk _____Meat _____

White Flour _____Sugar _____Alcohol _____Smoking _____Vape_____

Fruit _____Vegies _____Grains_____What type of oils _____

What types of food do you crave? Salty Chocolate Sweets Breads Other_____

How much daily energy? (1 = lowest, 10 = highest) _____

How much sleep do you get each night? _____How many times do you wake? _____What time?_____

How much Fun Sweaty Activity do you get each week?_____

What supplements/medications do you take?_____

_____

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I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food, supplements, and herbs as a guide to general good health.

I fully understand that those who counsel me are NOT medical doctors and I am not here for medical diagnostic purposes 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_____