Lise Ritter, Naturotherapist
102-1180 Cassells Street, North Bay, ON P1B 4B6

A Passion for Life

HEALTH ASSESSMENT INFORMATION

CLIENT NAME:_____ **DATE:**_____

Address:_____**P.C.**_____

Email _____ **Referred by:** _____

Phone:_____ **D.O.B.** _____

Emergency Contact: _____**Phone:** _____

Occupation: _____ **Stress: LOW MEDIUM HIGH**

Smoker: YES NO **Do you need a receipt for your insurance? YES NO**

Do you want to receive a monthly newsletter with recipes, health information, product promotions, draws, essential oil DIYs with the option to unsubscribe? YES NO

Allergies (food, medications, environmental)? YES NO (If yes, please list)

_____

_____

Under a Doctor's Medical Care? YES NO (If yes, for what condition)

_____

_____

Medications or supplements? (Name and dosage)

_____

_____

_____

Describe a typical day's dietary intake.

_____

_____

Describe level of activity/exercise? Sedentary Moderate High

_____

_____

Main goals are you looking to achieve.

_____

_____

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MEDICAL INFORMATION:

Do you currently have (or have you experienced) any of the following conditions?

Asthma _____ **Cancer/Chemo** _____
Constipation _____ **Diarrhea** _____
Diabetes _____ **Arthritis** _____
Epilepsy _____ **Eating Disorder** _____
Heart Problems _____ **Hearing Disorder** _____
Headaches _____ **Migraines** _____
High/Low BP _____ **HIV/AIDS** _____
Organ Transplant _____ **Poor Digestion** _____
Pregnancy _____ **Sleep Disorders** _____
Urinary T.I. _____ **Yeast Infections** _____
Varicose Veins _____ **Vision** _____
Hysterectomy _____ **Menopause** _____
Mental/Emotional _____ **Recent cold/flu** _____
Skin Disorders _____ **Respiratory Disorders** _____
Recent Injuries _____
Surgeries _____
_____
Other _____
_____

I, _____, understand that Aromatherapy, Massage, Reflexology, Reiki, Nutrition Counseling or any other holistic modality is not intended to replace allopathic methods of treatment, nor is it meant to be a diagnosis or cure.

I declare that the above information is true and complete to the best of my knowledge.

Signature: _____ Date: _____

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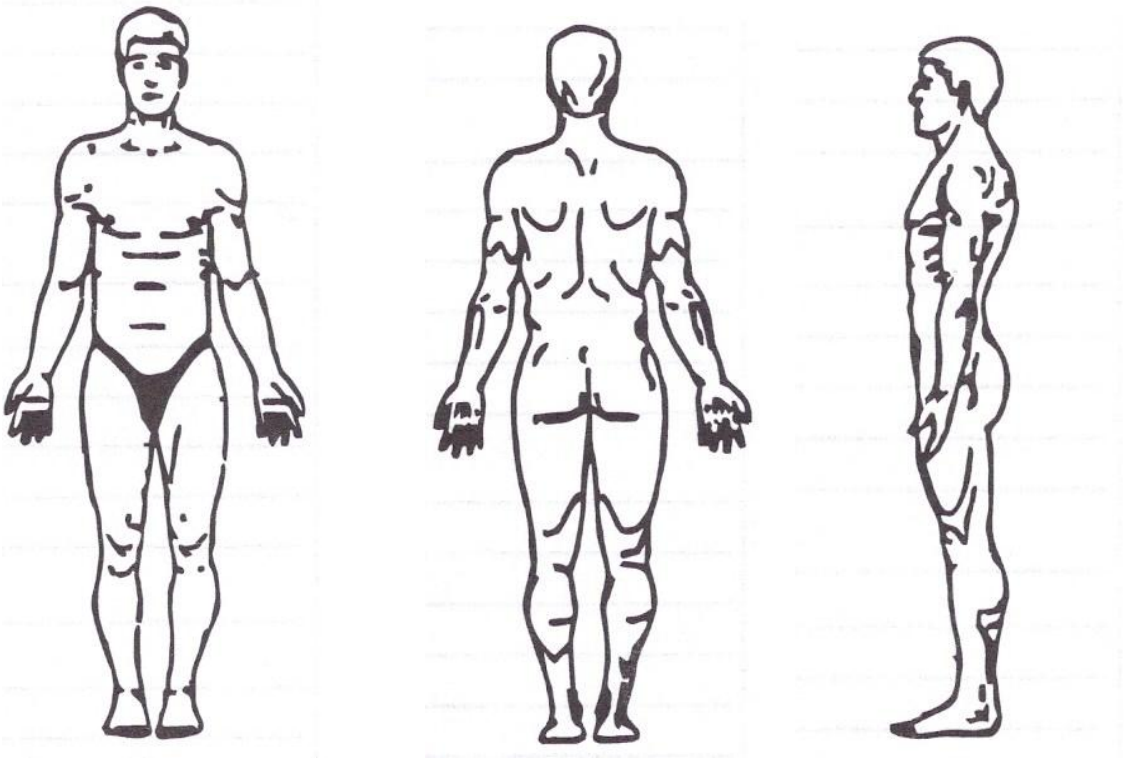

RESERVED FOR THERAPIST

Notes/Observations: _____

_____

_____

_____

_____

_____

_____

_____

Name of Therapist: **Lise Ritter n.p.** **ACNN Membership No:** **10-5407**

Foreseen number or frequency of visits:_____

_____

_____ _____

Signature of Therapist **Date**

liseritter@apassionforlife.ca 705-840-7014 ww.apassionforlife.ca