

Intake Data

Full Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

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 per week of these:

Fresh fruit _____ Raw vegetables _____ Fermented foods _____

Fast foods _____ Meat _____ Eggs _____ Dairy _____

What do you crave? _____

What foods do you dislike the most? _____

Why do you dislike them?_____

_____

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" in amount _____

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

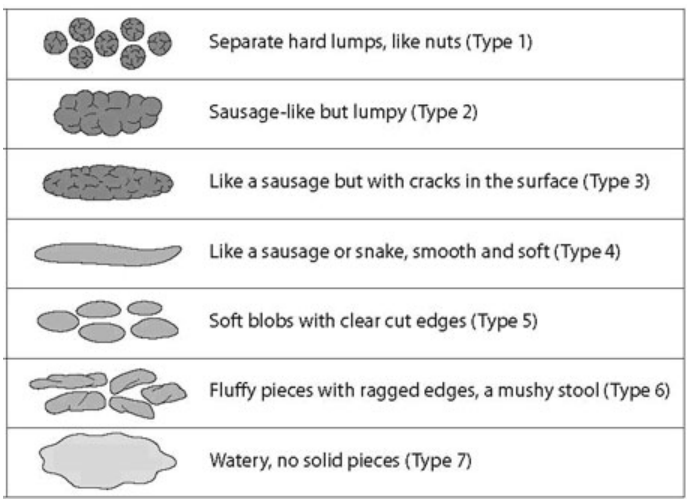
Do you have daily bowel eliminations? _____ If yes, how many per day?_____

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 Type # _____

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?_____

Is your flow longer or shorter than 5 days? _____

Do you have cramps or clotting?_____Do you experience PMS, cyclical headaches, or cravings? _____

Would you describe the color of your menses as more red, more purple, or more brown?

_____

Supplements/Medications

Do you take any supplements? _____ If so, what, how often and why _____

_____

Do you take any OTC medications routinely (such as Aleve or Aspirin)? _____

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 (including allergies) from a licensed medical professional?
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? _____

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 _____