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**Holistic Health Intake Form & Health Profile**

**PART ONE: PERSONAL INFORMATION**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Gender Identity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Ethnic/Cultural Background: Mother’s side \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father’s side \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_\_
Address Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell/pager):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Best Way to Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is Text ok? \_\_\_\_\_\_\_
Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Employment Status: Full time \_\_\_Part Time \_\_\_Retired \_\_\_Not employed \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Occupation/Student status: Full Time\_\_\_ Part Time \_\_\_Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Dependent Children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Children (#/ages): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How committed are you to healing yourself and changing your lifestyle (1-10) Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please complete this questionnaire as thoroughly as possible. The more information I have before we meet, the better prepared I can be to help you at your appointment.***

What health/wellbeing concerns brought you here today?
Primary issue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When did this begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Where is it located? What does it feel like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How severe is it? (on a scale of 1-10 where 10 is the worst you can imagine what level is it now?) \_\_\_ Past month \_\_\_\_

How long does it last? When does it happen? What makes it better or worse? Is there anything else that seems to relate to it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional comments:

Are you currently receiving care from any other health professional(s)? Medical doctor/ND/Nurse Practitioner/Psychiatrist (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you received a medical diagnosis? Yes \_\_\_ No\_\_\_
For what condition(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently using any supplements, vitamins, herbs, and/or pharmaceutical medication or drug? Please continue on a separate page if necessary. Please bring all your supplements, herbs, and/or medications to your first appointment if possible.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Pharmaceutical/Latin Name** | **Brand Name** | **Strength Dose** | **Frequency** | **How Long Have You Been Taking It?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Do you have any infectious diseases that you know of? Yes \_\_\_ No\_\_\_
If yes please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Is there any chance that you are pregnant? Yes\_\_\_\_ No\_\_\_

Do you have any known allergies or sensitivities (drugs, pollens, foods, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any reason you cannot ingest herbal remedies prepared in food-grade alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever undergone surgery or been hospitalized? (Please provide the date and reason) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any accidents or injuries in the last five years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
More than five years ago: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History** *Please complete this section only for any family members with particular health problems.***Relationship Health issue
Mother (\_\_\_\_ age):
Father (\_\_\_\_ age):
Siblings (\_\_\_\_age):
Children (\_\_\_\_ age):
Grandmother (\_\_\_\_ age):
Grandfather (\_\_\_\_ age):
Other:**

**Personal Health Information and Habits**

Height: \_\_\_\_\_\_\_\_\_\_

Current Weight: \_\_\_\_\_\_\_\_\_

Weight 1 year ago: \_\_\_\_\_\_\_\_\_\_

Ideal Weight: \_\_\_\_\_
Weight in your early 20’s (if older than 25): \_\_\_\_\_\_\_\_\_\_\_\_

Are you a smoker? Yes/No

Years? \_\_\_\_
Amount? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you smoked in the past? Yes/No

When did you quit? \_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? Yes No
What types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_times/week

Regular Exercise: Yes/No

|  |  |  |
| --- | --- | --- |
| **Type(s)** | **Frequency (times/week)** | **Duration** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Typical Diet – as accurately as possible please describe what you typically eat on a daily basis
Breakfast:**Good Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Bad Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lunch:**Good Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Bad Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Dinner:**Good Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Bad Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Snacks:**Good Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Bad Day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat sweets and desserts? \_\_Yes \_\_No
How often? \_\_\_\_\_\_\_times/week How much? \_\_\_\_\_\_\_ servings/day

Do you now or have you ever followed a restricted diet? Please describe and indicate when & for what reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes\_\_\_ No\_\_\_ If yes, what types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How often? \_\_\_\_\_\_\_\_\_\_\_times/week.

Do you drink coffee? Yes \_\_ No\_\_\_
How often? \_\_\_\_\_\_\_\_\_\_\_\_times/week How much? \_\_\_\_cups/day

Do you drink tea?
Black/Green? Yes\_\_ No\_\_
How often? \_\_\_\_\_\_\_\_\_\_\_\_times/week How much? \_\_\_\_cups/day
Herbal? Yes \_\_ No\_\_
How often? \_\_\_\_\_\_\_\_\_\_\_\_times/week How much? \_\_\_\_cups/day

Do you drink soda/pop? Yes\_\_\_ No\_\_\_
How often? \_\_\_\_\_\_\_\_\_\_\_\_times/week How much? \_\_\_\_cups/day

Do you make a point to drink water daily? Yes \_\_\_ No\_\_\_
How often? \_\_\_\_\_\_\_\_times/week How much? \_\_\_\_glasses/day

**PART TWO: HEALTH HISTORY** Please check those issues you have experienced in the last 3 months.

**Hair:**

**Skin:**

\_\_ Dry
\_\_ Moist
\_\_ Oily
\_\_ Red/Irritated
\_\_ Pale
\_\_ Feels cool/cold
\_\_ Feels warm/hot
\_\_ Nighttime sweating
\_\_ Daytime sweating
\_\_ Rashes
\_\_ Poor healing sores
\_\_ Hives
\_\_ Itching
\_\_ Eczema

\_\_ Psoriasis
\_\_ Pimples
\_\_ Acne

\_\_ Dandruff

\_\_ Irritated or itchy scalp

\_\_ Hair loss/Thinning
 – Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Recent moles of unusual shape or color

\_\_ Recent changes in skin texture

\_\_ Excessive hair growth

Any other noted problems with your skin, nails or hair? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head, Eyes, Ears, Nose and Throat**

**\_\_** Headache

\_\_ Migraines

\_\_ Poor vision

\_\_ Eye pain

\_\_ Redness in eyes

\_\_ Floaters

\_\_ Cataracts

\_\_ Glaucoma

\_\_ Blurred vision

\_\_ Loss of vision

\_\_ Earaches

\_\_ Poor hearing

\_\_ Ringing in ears

\_\_ Swishing sound in ears

\_\_ Fullness in ears

\_\_ Discharge from ears

\_\_ Sore throat

\_\_ Bleeding gums

\_\_ Canker sores

\_\_ Cold sores, if yes how often? \_\_\_\_\_\_\_\_\_times/year \_\_ Grinding teeth

\_\_ Facial pain

\_\_ Clicking jaw

\_\_ Jaw pain

\_\_ Mucous in throat

\_\_ Nosebleeds

\_\_ Dizziness

\_\_ Frequent colds

\_\_ Swollen glands

\_\_ Nose Bleeds

\_\_ Allergy symptoms

Any other problems with your head, eyes, ears, nose or throat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Respiratory**

\_\_Cough

 \_\_chronic

 \_\_acute

\_\_ Clear/white mucus
\_\_ Yellow/green/orange mucus
\_\_ Bronchitis

\_\_ Coughing blood

\_\_ Pneumonia

\_\_ Pain on breathing

\_\_ Shortness of breath without exertion
\_\_ Difficulty breathing when lying down

\_\_ Production of phlegm, if yes what color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Sinus infection(s)

\_\_ Asthma

\_\_ Hay fever/Allergic rhinitis
\_\_ Seasonal Allergy Symptoms
\_\_ Runny/stuffy nose

\_\_ Bronchitis

\_\_ Emphysema

\_\_ Other allergies such as mold, dust, chemicals, cleaning products, scents, perfumes, paint etc.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_ Any other respiratory issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular**\_\_High blood pressure - specify if known\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_Low blood pressure - specify if known\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Chest/heart pain
\_\_ Fainting
\_\_ Irregular Heartbeat
\_\_ Cold hands or feet

\_\_ Numbness or tingling in
 fingers or toes

\_\_ Ankle swelling
\_\_ Palpitations
 \_\_ with anxiety
 \_\_ without anxiety

\_\_ Easy bruising
\_\_ Varicose veins
\_\_ Blood clots
\_\_ Breathing difficulties
\_\_ Hemorrhoid

Any other concerns with your heart or circulation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastro-Intestinal**

\_\_ Nausea
\_\_ Vomiting
\_\_ Diarrhea
 – for how long \_\_\_\_\_\_\_\_\_\_\_
 – color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_ Constipation
\_\_ Alternating diarrhea &
 constipation
\_\_ Unusual color of stool
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_ Bad breath
\_\_ Indigestion
\_\_ Abdominal pain
\_\_ Heartburn
\_\_ Gas
\_\_ Bloating
\_\_ Blood in stools
 – what color\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_ Mucous in stools
\_\_ Rectal pain
\_\_ Hemorrhoids
\_\_ Parasites
\_\_ Food cravings
 – specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_ Poor appetite
\_\_ Gallstones
\_\_ Ulcers
\_\_ Difficulty swallowing
\_\_ Colitis/IBS
\_\_ Liver problems
\_\_ Hepatitis
\_\_ Dysentery

How many bowel movements do you have a day? (if less the 1/day – how often) \_\_\_\_\_
How would you describe your bowel movements? \_\_Loose \_\_Normal \_\_Hard \_\_\_Tarry\_\_ Varied\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do your stools: float? \_\_sink? \_\_\_ have a bad odor? \_\_\_have no odor? \_\_\_display blood?
Do you rely on: \_\_\_Enemas \_\_\_Laxatives \_\_\_Coffee \_\_\_Cigarettes or \_\_\_Purgatives for bowel elimination?
If yes, how often? \_\_\_\_\_\_times/week Any other digestive problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any known food allergies or sensitivities – or have you noticed digestive issues sometimes after eating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Do you avoid any particular foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urinary/Kidneys**

**\_\_** Irregular Flow
\_\_ Dark color
\_\_ Light yellow/ Pale flow
\_\_ Painful urination
\_\_ Difficulty holding urine

\_\_ Frequent urination
(day \_\_\_\_ or night\_\_\_\_\_)
\_\_ Decrease in flow
\_\_ Blood in urine
\_\_ Water retention
\_\_ Urgency of urination
\_\_ Burning urine
\_\_ Kidney/bladder stones
\_\_ Difficulty stopping or starting
\_\_ Interstitial cystitis

Any other problems with urination or kidney function? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Musculoskeletal/Nervous System**

\_\_ Muscle weakness
\_\_ Muscle Tension
\_\_ Reduced range of
 movement
\_\_ Neck pain
\_\_ Muscle pain
\_\_ Stiffness
\_\_ Back pain
\_\_ Jaw pain
\_\_ TMD or TMJ
\_\_ Arthritis:
 \_\_ Osteo-
\_\_ Rheumatoid
\_\_ Shooting pains
\_\_ Paralysis

\_\_ Dizziness
\_\_ Fibromyalgia
\_\_ Stiff joints
\_\_ Swollen joints/fluid in joints
\_\_ Joint pain
\_\_ Acute injury

 \_\_Chronic pain/old
 injury
\_\_ Broken bone
\_\_ Sprain
\_\_ Strain
\_\_ Numbness

\_\_ Tingling- where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_ Seizures
\_\_ Issues with taste or smell\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_ Memory loss

Do you see a Chiropractor or Massage Therapist? (Please provide name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Any other musculoskeletal problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Endocrine/Metabolic**

\_\_ Sensitive to heat/cold
\_\_ Intolerance to heat or cold \_\_ Excessive sweating
\_\_ Night sweats
\_\_ Hypoglycemia

 \_\_ Insulin resistance \_\_ Dry Skin
\_\_ Hypothyroid
\_\_ Hyperthyroid
\_\_ Hashimoto
\_\_ Chronic fatigue
\_\_ Fevers
\_\_ Chills
\_\_ Excessive thirst
\_\_ Slow metabolism
\_\_ Sudden energy drops
\_\_ Recent weight gain
\_\_ Recent weight loss

Any other health concerns or problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reproductive Information:**

Are you taking synthetic hormones? Yes No
Which one(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Are you taking natural hormones? Yes No
Which one(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any other medication for the reproductive system? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Have you had any surgeries of the reproductive organs? Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently or have you transitioned between genders?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
M->F\_\_\_\_\_ or F->M\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_
If so, what physical or emotional changes have you noticed if any?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any related information or concerns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reproductive & Hormonal**

\_\_ Benign prostatic hypertrophy or hyperplasia (BPH)
\_\_ Bleeding w/ ejaculation
\_\_ Candida albicans
\_\_ Epididymitis

\_\_ Frequent urination, if so
 – How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?

\_\_ Difficulty achieving or maintaining an erection
\_\_ Lack of or Low libido
\_\_ Low sperm count
\_\_ Pain in the prostate region
\_\_ Premature ejaculation
\_\_ Prostate cancer
\_\_ Testicular cancer
\_\_ Cancer of the penis
\_\_ Trauma (sexual/reproductive)

\_\_ Urine dribbling or leakage
\_\_ Poor Urine Flow Rate-weak stream

\_\_ Acne
\_\_ Anemia
\_\_ Candida albicans
\_\_ Cervical dysplasia

\_\_ Discharge other than menstruation, if yes
 – What is the color? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Endometriosis
\_\_ Estrogen: low\_\_\_ high\_\_\_\_
\_\_ Fibroids
\_\_ Hysterectomy
\_\_ Infertility or difficulty conceiving

\_\_ Lumpectomy
\_\_ Mastectomy
\_\_ Ovulation issues
\_\_ Pain with intercourse
\_\_ PCOS (Polycystic Ovarian Syndrome)

\_\_ Pelvic inflammatory disease
\_\_ Progesterone: low\_\_ high\_\_\_
\_\_ Prolactin: high\_\_\_\_

\_\_ Testosterone: low\_\_\_ high\_\_\_
\_\_ Tubal ligation
\_\_ Uterine cysts
\_\_ Vaginal infection
\_\_ Vaginal itching

\_\_ Any other concerns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Sexually transmitted diseases (STD’s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you menstruate? \_\_ Yes \_\_ No If yes, what is the length of your cycle (period to period): \_\_\_\_\_\_\_\_ days
Duration of bleeding \_\_\_\_\_\_\_\_ days?

Would you characterize your flow as: \_\_ Heavy \_\_\_ Normal \_\_\_ Light?

Is the blood: \_\_ Dark red \_\_ brown \_\_ red \_\_\_ Light red/watery?

 Menstrual Cycle: \_\_ Regular \_\_ Irregular \_\_ Absent (how long) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have premenstrual symptoms (PMS)? \_\_\_ Yes\_\_\_ No

How many days before your cycle do symptoms begin to manifest? \_\_\_\_\_\_ days before period

If you have PMS, which symptoms apply to you?

\_\_ Abdominal pain
\_\_ Anxiety
\_\_ Back or neck pain or tension \_\_ Bloating
\_\_ Breast tenderness
\_\_ Foggy Thinking
\_\_ Craving for sweets
\_\_ Depression
\_\_ Dizziness

\_\_ Fatigue:
 – when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Grief
\_\_ Headaches
\_\_ Increased appetite
\_\_Insomnia
\_\_ Joint pain

\_\_ Migraines (when in cycle\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
\_\_ Mood Swings
\_\_ Nervous tension
\_\_ Nervousness
\_\_ Palpitations
\_\_ Poor memory
\_\_ Water retention
\_\_ Weight gain

Date and result of last PAP smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many have you had?
\_\_\_ Births? \_\_\_ Miscarriages? \_\_\_ Premature births? \_\_\_ Abortions?

Do you or have you recently used contraceptives? \_\_ Yes \_\_ No
If yes, which ones? \_\_ IUD \_\_ Condoms \_\_ Diaphragm \_\_ Rhythm \_\_ Mucous method \_\_ Spermicidal jelly

\_\_ Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you post-menopausal? \_\_ Yes \_\_ No

If yes, when was the approximate date of your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have menopausal symptoms, please describe your major symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any other gynecological issues or concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Connection to Nature**

Do you connect with nature on a daily basis? \_\_ Yes \_\_ No

In what ways do you connect with nature?

\_\_ Hiking

\_\_ Sit under a tree

\_\_ Work in the garden/yard

\_\_ Take care of house plants

\_\_ Notice the plants in your
 city/neighborhood

\_\_ Spend time at a park

\_\_ Lay on the grass

\_\_ Stand barefoot on the Earth

\_\_ Sit next to water (steam, river, fountain, etc)

\_\_ Swimming

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you do take time to connect with nature daily, do you notice how it affects you? (calms nerves, feeling more grounded, deeper breathes, more clarity/focus, uplifts mood, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Psychological/Emotional –** check any symptoms you are currently/recently experiencing. If in the past write (p) next to the check box and when if you remember.

\_\_ Severe headaches
\_\_ Panic attacks
\_\_ Low self-esteem
\_\_ Dizziness/faintness
\_\_ Shortness of breath
\_\_ Crying spells
\_\_ Numbness/tingling
\_\_ Fear of dying
\_\_ Guilt feelings
\_\_ Periods of anxiety
\_\_ Irritability
\_\_ Temper outbursts

\_\_ Excessive sweating
\_\_ Agitation
\_\_ Poor judgment
\_\_ Heart racing/pounding
\_\_ Loss of appetite
\_\_ Aggressive behaviors
\_\_ Trembling/shaking
\_\_ Memory problems
\_\_ Suicidal thinking
\_\_ Excessive fears
\_\_ Exhaustion/tiredness
\_\_ Depressed mood
\_\_ Poor concentration
\_\_ Nightmares
\_\_ Recurrent intrusive thoughts
\_\_ Severe worry
\_\_ Sleeping excessively

\_\_ Urges to perform repeated acts
\_\_ Nervousness
\_\_ Insomnia
\_\_ Sexual problems
\_\_ Periods of feeling too good/high
\_\_ Difficulty falling asleep
\_\_ Constant tension
\_\_ Frequent awakening

**Additional**

\_\_ Poor sleep
\_\_ Poor memory
\_\_ Numbness
 – where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Irritability
\_\_ Seizures
\_\_ Migraine
\_\_ Headaches
\_\_ High stress levels
\_\_ Fatigue
\_\_ Lack of motivation
\_\_ Loss of balance
\_\_ Lack of coordination
\_\_ Difficulty concentrating
\_\_ Foggy or spacey feeling
\_\_ Muscle spasm/twitching

How many hours do you sleep each night? \_\_\_\_\_\_

Do you have any other neurological problems/concerns?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins encountered beyond what might be expected in one’s day to day life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Outlook on Life**

*How do you feel about the following areas of your life? Please check the appropriate boxes and make any comments you would like to.*
**Excellent - Good - Fair - Poor**

 • **Self**

 • **Spouse/Partner**

 • **Sex**

 • **Family**

 • **Life purpose**

 • **Finances**

Are you able to express your feelings and emotions easily? \_\_ Yes \_\_ No

Is there an excess of stress in your life? \_\_ Yes \_\_ No

If yes, what is causing you stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have tools or techniques to relieve stress? \_\_ Yes \_\_ No

Are you satisfied with your current living/working environment? \_\_ Yes \_\_ No

If there is one thing in your life that you would like to change right now, what is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience frequent worry? \_\_\_ Yes \_\_ No

If yes, what things make you most worried? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you sleep well? \_\_ Yes \_\_ No

What feelings do you most often experience in your life?

\_\_ Joy

\_\_ Happiness
\_\_ Acceptance
\_\_ Anger
\_\_ Sadness

\_\_ Fear

\_\_ Anxiety

\_\_ Sympathy

\_\_Worry
\_\_ Depression

\_\_ Guilt Confusion
\_\_ Self-doubt

**Vision Statement** What is your desired goal for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Waiver of Liability** I, the undersigned, confirm that I am consulting with Kassaundra Lynn to receive a general assessment of my wellbeing and that she is not licensed as a physician to diagnose or treat any illness, medical condition, or disorder, nor to prescribe medications. I understand that there will be no diagnosis made, nor prescriptions given, but rather that will offer an assessment of my general physical and/or emotional wellbeing, as well as dietary, herbal, nutritional, and other recommendations to support my health and emotional balance. I understand that the information received in this and any consultation with is not in any way to be considered medical advice, nor is it to be considered a substitute for medical advice. I understand that it is important that I continue to seek medical care with my medical doctor, and other health care practitioners as usual, and to confirm any addition of herbs and supplements to my diet with this healthcare provider if I am taking prescription medications or have been diagnosed with a medical diagnosis. If I am already taking prescription medications of any kind, I confirm that I will not discontinue use of such medications without consulting with my prescribing healthcare provider. I also understand the importance of frequent monitoring of any new health supporting protocol to revise the recommended protocol as appropriate, and confirm that I will immediately report any new or unusual symptoms to and to my physician (if I am currently seeing a physician for a medical condition or illness).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***All case history notes and medical information recorded during the consultation are kept strictly confidential. Your personal and health related information will not be released to any person or agency except with your authorization or where required by law.***