Information Sheet

Name____ Phone _______________________________
Address ____ Other Phone ______________________________
City ____ State/Zip________________________________
Email ___________________________________

Relief from what symptoms? ____

How much movement/exercise weekly? __________________________

What type of activity? _______________________

How many ounces of water do you drink daily? ________________ Type? RO Tap Spring Distilled

Which meals eaten daily? Breakfast Lunch Supper

How many bowel eliminations per day? ____ Color/consistency? ____________________________________

Urinary?______ Color? _________________________________

How many digestive enzymes daily? ________ How many breathing exercises daily? ___________

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

Soda pop _________ Coffee ________ Smoking ___________ Alcoholic Bev __________ Fast food _________

Milk___________ White Flour _________ Sugar usage ___________ Raw fruit__________ Meat __________

Raw Veggies ________ Whole Grains __________

Comment on specifics of the above. (Diet soda? Decaf coffee? Red wine? Raw milk? et al….) _____________________
____

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

What are your favorite foods?
____

How much daily energy (1 = lowest energy level; 10 = highest energy level) do you have? _________________________

Any surgeries? Yes No If Yes, what and when? ____
____

How many hours of TV do you watch daily? _________________

How many hours of “you time” do you spend each day? (prayer, meditation, naps, church, reading, study, etc.)
____

How many hours a week do you spend with family/friends?______ Social? ___________ Obligation? __________

How many hours of sleep do you get each night? _______________ How many hours do you need? ________________

Prescription meds? Yes No If Yes, what/why/how long? ____
____

Who referred you for your appointment today? ____

I understand that I am here to learn about food choices, lifestyle and natural health practices, and that I will be offered information about food, nutritional supplements, herbs and homeopathy, based on sound scientifically-supported study. I have come of my own free will and acknowledge that (printed name)___________________________________, (signature)_____________________________, will offer assessments based on formal training in natural health, and holistic ministry.

I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnoses 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 matters intended for the maintenance of the best possible state of natural health and stewardship of the body, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature____ Date _____________________________________

Symptoms, Medical Diagnoses (by a licensed medical practitioner) and/or Areas of Concern:

(circle or underline all that apply)

Acne
ADD/ADHD
Adrenal Glands
Allergies
Alzheimer’s Disease
Anemia
Anger
Anxiety
Appetite
Arteriosclerosis
Arthritis
Asthma
Back Pain
Bad Breath
Bed Wetting
Bell’s Palsy
Bites
Bladder
Blood Pressure - High
Blood Pressure - Low
Boils
Bones
Breathing
Bronchitis
Bruises
Burns
Cancer
Candida
Canker Sores

Circulation
Cold - Common
Cold - Temperature
Colic
Colon
Constipation
Cough
Cravings
Dandruff
Depression
Diabetes
Diarrhea
Digestion
Dizzy Spells
Ear Infection
Ear Ringing
Edema
Emphysema
Epilepsy
Eyesight
Fatigue
Fever
Flu
Gallstones
Gangrene
Gas
Gout
Gums
Hair Issues

Hiatal Hernia
Hives
Hormones
Hyperactive
Hypertension
Hyperthyroidism
Hypoglycemia
Impotence
Incontinence
Indigestion
Insomnia
Joint Pain
Kidney Issues
Kidney Stones
Laryngitis
Leprosy
Leukemia
Liver Stress
Lung Issues
Lupus
Lymph Glands
Menopause
Menstrual Cramps
Migraines
Mononucleosis
Mucous
Nails
Nausea
Nervousness

Pneumonia
Polyps
Pregnancy
Prostate
Psoriasis
Rash
Reproductive
Respiratory
Rheumatism
Ringworm
Seizures
Shingles
Sinus
Skin Issues
Snoring
Sore Throat
Stomach

Stroke
Sty
Teething
Tennis Elbow
Tonsillitis
Tumors
Ulcers
Urinary Infections
Varicose Veins
Vertigo
Weight - Overweight

Carpal Tunnel	Headache	Nose Bleeds	Weight - Underweight
Cataracts	Heart Issues	Parasites	Yeast Infections
Chest Congestion	Heartburn	Parkinson’s Disease	OTHER: _______________
Chest Pain	Hemorrhoids	Perspiration	______________________
Cholesterol	Herpes	PMS	______________________

NOTES: