



### 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	Circulation	Hiatal Hernia	Pneumonia
ADD/ADHD	Cold - Common	Hives	Polyps
Adrenal Glands	Cold - Temperature	Hormones	Pregnancy
Allergies	Colic	Hyperactive	Prostate
Alzheimer's Disease	Colon	Hypertension	Psoriasis
Anemia	Constipation	Hyperthyroidism	Rash
Anger	Cough	Hypoglycemia	Reproductive
Anxiety	Cravings	Impotence	Respiratory
Appetite	Dandruff	Incontinence	Rheumatism
Arteriosclerosis	Depression	Indigestion	Ringworm
Arthritis	Diabetes	Insomnia	Seizures
Asthma	Diarrhea	Joint Pain	Shingles
Back Pain	Digestion	Kidney Issues	Sinus
Bad Breath	Dizzy Spells	Kidney Stones	Skin Issues
Bed Wetting	Ear Infection	Laryngitis	Snoring
Bell's Palsy	Ear Ringing	Leprosy	Sore Throat
Bites	Edema	Leukemia	Stomach
Bladder	Emphysema	Liver Stress	
Blood Pressure - High	Epilepsy	Lung Issues	Stroke
Blood Pressure - Low	Eyesight	Lupus	Sty
Boils	Fatigue	Lymph Glands	Teething
Bones	Fever	Menopause	Tennis Elbow
Breathing	Flu	Menstrual Cramps	Tonsillitis
Bronchitis	Gallstones	Migraines	Tumors
Bruises	Gangrene	Mononucleosis	Ulcers
Burns	Gas	Mucous	Urinary Infections
Cancer	Gout	Nails	Varicose Veins
Candida	Gums	Nausea	Vertigo
Canker Sores	Hair Issues	Nervousness	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: