|  |  |  |
| --- | --- | --- |
| Name:       | Phone:       | Email:       |
| Address:       |
| Birthdate:       | Height:       | Weight:       |
| How did you hear about me?       |

What are your health concerns and goals?

|  |  |  |
| --- | --- | --- |
| Do you smoke?       | Drink Alcohol?       | How much/when?       |
| Do you drink caffeine every day?       | When/in what forms?       |
| How much water do you drink each day?       |  Is the water filtered?       |
| Do you have food allergies, sensitivities, or restrictions?       |
| Describe daily energy levels:       |
| Do you get noticeably irritable, light-headed, or weak if you haven’t eaten in awhile?       |

Do you crave any of the following?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sugar       | Meat Fat       | Chocolate       | Fish       | Alcohol       |
| Desserts       | Milk       | Bread       | Fried Foods       | Other       |
| Do you cook your own food?       |  What percentage of food is home-cooked?       |
| Do you eat organic food?       |  How often and which foods?       |
| Do you eat animal protein?       | How often?       |
| Are you a Vegetarian or Vegan?       | For how long?       |
| Do you use a microwave oven?       | How often?       |

Which oils do you use/consume? (mark with an x)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Butter    | Peanut Oil    | Canola    | Margarine    | Corn Oil    | Sun/Safflower    | Olive Oil    |
| Crisco    | Mayonnaise    | Coconut Oil    | Vegetable    | Flaxseed    | Soybean    | Other       |
| How many diets have you been on?       | Which ones:       |

What were the outcomes?

|  |  |
| --- | --- |
| Have you take antibiotics in the past?       | How recently?       |

How is your dental health?

Please list any nutritional supplements/vitamins you take with Brand Names:

|  |
| --- |
|       |
|       |
|       |
|       |

Please list prescription drugs or over-the-counter medications you take regularly:

|  |
| --- |
|       |
|       |
|       |

Please list any surgeries and the year of occurrence:

|  |  |  |
| --- | --- | --- |
| How many bowel movements do you have daily?       | What consistency?       | Color?       |
| Rank you skin without lotion: | Very Dry       | Dry       | Normal       | Oily       | Combination       |

Please check off any off the following that pertain to you - **type [p] for past or [c] for current**

    Acne

    Addiction (drugs or alcohol)

    Anemia

    Anorexia / Bulimia

    Anxiety or nervousness

    Arthritis (Rheumatoid - Osteo)

    Autoimmune

    Birth control pills

    Bladder infections – UTIs

    Bloating, gas, or indigestion

    Blood sugar problems

    Bronchitis

    Cancer

    Children

    Chronic Fatigue

    Colds or flu (frequent)

    Constipation

    Dandruff

    Depression

    Diabetes I or II

    Diarrhea

    Difficulty gaining weight

    Difficulty losing weight

    Emotional problems

    Emphysema

    Fainting

    Gall bladder problems

    Gout

    Hair loss or poor growth

    Hashimotos or Graves

    Headaches

    Heart disease or problems

    Heartburn

    Hemorrhoids

    High blood pressure

    High cholesterol

    HIV

    Hot flashes

    Hypoglycemia

    Hysterectomy

    Insomnia

    Irregular periods

    Kidney stones

    Liver problems

    Loose Stools

    Loss of periods

    Memory loss or confusion

    Menopause

    Nails, poor growth

    Painful intercourse

    Painful periods

    Panic Attacks

    Parasites

    PMS

    Pregnant or nursing mother

    Respiratory problems

    Ringing in ears

    Seizures

    Severe mood swings

    Skin conditions

    Suicidal tendencies

    Thyroid condition

    Ulcer

    Yeast infections

Please list any disease, illness, in immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease):

How well do you sleep?       Typical bedtime       Typical waking time

Do you fall asleep within 15 minutes of going to bed?       Do you sleep through the night?

Do you wake feeling refreshed?       Do you wake without an alarm?

Do you exercise?       If yes, What kind? / Frequency? / Since when?

Please rate the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Daily energy level: | Excellent       | Good       | Fair       | Poor       |
| Energy level after exercise: | Excellent       | Good       | Fair       | Poor       |
| Daily stress level: | Very high       | High       | Moderate       | Low       |
| General enjoyment of life: | Excellent       | Good       | Fair       | Poor       |

By signing below, you acknowledge that any nutritional program suggested is not intended as a treatment for any disease. The intent of any nutritional recommendation is to support the physiological and biochemical processes of the human body, and not to diagnose, treat, cure, prevent any disease or condition. Always work with a qualified medical professional before making changes to your diet, prescription medication, lifestyle or exercise activities.

Signed:

Date: