NATURAL HEALTH ALTERNATIVES

Date _______________

Name:____ Date of Birth_______________

Address: ____

Phone:(H)__________________________(W)__________________________(C)__________________________

E-mail: ____

Occupation and/or student course of studies:

____

How did you hear of my services? ____

Reason for appointment:

____

What do you hope to gain from working together? ____

____

Current Physician_____________________________ Last Appointment_____________________________

May I have your permission to consult with your physician? Please initial. _________________________

List all physical, mental and emotional conditions/symptoms and your current means of treatment:

Conditions:	Treatment/Medications
____	____
____	____
____	____
____	____
____	____
____	____
____	____

Please use a separate page if needed to list all current conditions and medications/treatment

Please list any known allergies. ____

How many times have you taken anti-biotics in the last 5 years? _____ 10 years? ____ 20 years? _____

Do you have/get yeast infections, nail fungus, athlete's foot now or in past? _____________________

Are you aware of having had exposure to mold in your home, workplace or other? ______________

If yes, please explain. ____

Have you ever been bitten by a tick? ________ How many times? ________ When? ___________

If yes, what type of reaction did you have, if any? ____

Have you ever been tested for Lyme Disease? ____

Do you smoke? ___________ If so, how much per day? _________________________

Do you drink alcohol? ____________If so, what and how often? _________________________

Do you use artificial sweeteners, such as Nutrasweet, Splenda, Equal, Sweet N Low? _______________

If so, how often?____

Do you eat or drink diet products?________________ If so, how often ___________________________

What do you normally eat for breakfast? ____

What do you normally eat for lunch? ____

What do you normally eat for dinner? ____

Do you eat fast food or processed foods? _________ If so, how often? _____________________________

Do you eat organic foods? __________If so, what % of your daily food intake is organic? _____________

How many bowel movements do you have a day?______ A week? _____ Are they productive? _______

How much water do you drink a day? ____

What type of water do you drink, tap, bottled spring, bottled mineral?______________________________

What other liquids do you drink? ____

Do you take vitamin and mineral supplements? ____

If so, what and how often? ____

Do you exercise? ____

If so, what type and how often? ____

How would you describe yourself? **Mark an X with all that apply.**

___ Happy
___ Open minded
___ Energetic
___ Have many friends
___ Live an active life
___ Confident
___Enjoy thinking deeply
___ Self Nurturing
___ Have loving family relationships
___ Enjoy your work
___Get plenty of restful sleep each night
___ Love your life

___ Sad or depressed
___ Closed minded
___ Tired or fatigued
___ Have few friends
___ Live a sedentary life
___ Lack self confidence or feel inferior
___ Do not enjoy having to think
___ Do not take care of self
___ Family relationships do not feel loving
___ Do not enjoy your work
___ Do not sleep well
___ Feel unhappy with your life

One a scale of 1-10 (10 being the highest) please circle your perceived level:

Your level of stress	1	2	3	4	5	6	7	8	9	10
Your quality of sleep	1	2	3	4	5	6	7	8	9	10
Your level of energy	1	2	3	4	5	6	7	8	9	10
Your level of happiness	1	2	3	4	5	6	7	8	9	10