



Date ..... Referred by .....

Are you subscribed to my e-newsletter?.....Would you like to be added?.....

Name ..... Email .....

Address ..... Apt..... City/State..... Zip.....

Phone - Work ( ) .....Home ( ) .....Cell ( ).....

Age ..... Date of Birth ..... Height .....

Ethnic background/Birthplace .....

Current weight ..... Weight six months ago? ..... One year ago? ..... : Ideal Weight .....

Relationship status.....Children? .....

Occupation ..... How many hours a week do you work? .....

Do you fall asleep well? Stay asleep or wake up at night? Do you generally feel you have good energy?

**FOR WOMEN ONLY**

Periods regular? ..... How many days is your flow? ..... How frequent? .....

Painful or symptomatic? .....Any clotting? .....

Heavy or light flow? .....

**Please check any that generally apply to you. If female, please mark if the pre-menstrual/menses symptoms.**

	Generally	PMS	Menses		Yes	No
Bloating				Feel cold often?		
Breasts Tender				Dislike the cold?		
Cramping				Feel hot often?		
Moodiness/Irritable				Dislike the heat?		
Depression				Daytime sweats?		
Anxiety				Nighttime sweats?		
Highly emotional				Sweaty palms or soles of feet?		
Mental Fogginess				Cold hands or feet?		
Low back pain				Frequent urination?		
Neck/ Shlder pain				Dark urine?		
Headaches				Any Heart concerns?		
Dizzy				Any respiratory concerns?		
Water retention				Ringing in the ears?		
Mucus Issues				Dry Skin		
Acne/Skin eruption				Breast Fed as a baby?		

How is your digestion? Constipation / Diarrhea/ Gas? .....

**Birth control pill history** (please list total years) .....

**Antibiotic** history (how often) .....

Any other **long term prescription drug** use? .....

Any problems with your thyroid? .....

Yeast infections common? .....

Last Cholesterol reading and date: ..... Blood type: .....

Do you have any pain, stiffness or swelling in your body? .....

Any hospitalizations / injury:

Any current or past diseases, viruses or infections?

Please list any past or current diseases or disorders than run in your family, with the family member affected:

Please list current supplements and medications:

Vitamins/Food Based:

Prescription:

Other: Over the Counter Meds

Are there any other healers, helpers or therapies with which you are involved? Please list:

What role does exercise play in your life (explain)?

Do you follow a regular awareness practice? (mediation, prayer, affirmation, etc. Please explain frequency and importance in your life)

Use a microwave? ..... Aluminum or Teflon cookware? .....

Do you drink coffee? .....

Alcohol? .....

Smoke? .....

Any other addictions present or past (food related or other)?

What percentage of your food is home cooked ? .....% Where do you get the rest from?

**Please list your chief health concerns that you would like to improve, physical or emotional.**

1. ....

2. ....

3. ....

4. ....

Other concerns, physical or emotional/spiritual?

How is the health of your mother?

How is the health of your father?

Please list what you usually eat for:

**Breakfast**

**Mid Morning Snack**

**Lunch**

**Afternoon Snack**

**Dinner**

**Desserts**

**Liquids**

Has your eating changed much in the past year? If so, how?

What foods did you eat as a child?

Is your diet mostly cooked, raw or a combination?

**Please circle if you eat the following. Place an "O" next to the word for often, or "S" for sometimes:**

Beef	Cow Milk	Pastries/ cookies/ candy	<b><u>Like (+) or dislike (-):</u></b>
Chicken	Goat milk products	Margarine/Shortening	Spicy
Pork	Cheese	Fried foods	Bitter
Eggs	Butter	Yogurt or ice cream	Salty
Fish	Sushi or raw meat		Sweet
			Sour

Brown or White Rice	Wheat bread	Beans	Nut butters/Tahini
Amaranth	White pasta or Wheat pasta	Tofu or Tempeh	
Millet	Buckwheat	Miso	
Quinoa	Oats	Nuts and/or seeds	

**Please list fruit and veggies you usually eat:**