

**\*\*ALL INFORMATION WILL BE KEPT CONFIDENTIAL\*\***

## PERSONAL INFORMATION

FIRST NAME:

LAST NAME:

EMAIL:

BEST PHONE#(S):

AGE:

HEIGHT:

BIRTHDATE:

CURRENT WEIGHT:

WEIGHT 1 YEAR AGO:

IDEAL WEIGHT:

## MEDICAL INFORMATION

### PLEASE LIST THE FOLLOWING:

DIAGNOSED DISEASES:

ALLERGIES / SENSITIVITIES:

DIGESTIVE ISSUES (GAS, BLOATING, CONSTIPATION, ETC.)

PAIN, SWELLING, JOINT ISSUES:

MEDICATIONS:

SUPPLEMENTS:

FAMILY HISTORY / GENETIC CONCERNS:

PLEASE LIST YOUR MAIN HEALTH CONCERNS:

PLEASE LIST YOUR MAIN HEALTH GOALS:

## DIET INFORMATION

WHAT CHANGES DO YOU THINK YOU SHOULD MAKE TO YOUR DIET, IF ANY?

WHAT ARE YOUR COMMON FOOD PREFERENCES CURRENTLY?

BREAKFAST

LUNCH

DINNER

SNACKS

LIQUIDS

HOW MUCH WATER DO YOU DRINK PER DAY (IN OUNCES)?

NICOTINE?

MARIJUANA?

HOW MANY CUPS OF COFFEE DO YOU DRINK PER DAY?

DO YOU CRAVE SUGAR?

DO YOU DRINK ALCOHOL?

IF SO, HOW MUCH:

OTHER CRAVINGS/ADDICTIONS:

HOW WELL DO YOU SLEEP?

HOW MANY HOURS?

DO YOU WAKE UP AT NIGHT?

IF SO, WHY?

## OTHER INFORMATION

RELATIONSHIP STATUS:

OCCUPATION:

WORK WEEK (HRS):

DO YOU LIKE WHAT YOU DO?

HOW LONG IS YOUR COMMUTE PER DAY (HRS):

CURRENT RESIDENCE:

CHILDREN & AGES:

WHAT TYPE OF EXERCISE / SPORTS DO YOU ENJOY DOING AND HOW OFTEN?

LIST ANY SPIRITUAL PRACTICES (PRAYER, MEDITATION), HEALERS, THERAPIES YOU CURRENTLY USED OR THAT HAVE WORKED FOR YOU IN THE PAST:

WHAT HOBBIES DO YOU ENJOY, OR WOULD YOU LIKE TO TRY?

## WOMEN'S INFORMATION

ARE YOUR PERIODS AND FLOW IRREGULAR OR INCONSISTENT?

PAINFUL OR SYMPTOMATIC?

IF EITHER OF THE ABOVE, PLEASE ELABORATE:

REACHED OR APPROACHING MENOPAUSE? PLEASE EXPLAIN:

BIRTH CONTROL HISTORY:

ANY HORMONAL CONCERNS?

PERIODIC YEAST AND/OR URINARY TRACT INFECTIONS? PLEASE EXPLAIN: