HOW HEALTHY DO YOU FEEL?

Name_________________________________ Phone#______________________ Date___________

ADDRESS____

____

Newsletter Y/N____ E-MAIL_________________________________

AGE_____ SEX_____ HEIGHT_____ WEIGHT_____ BLOOD TYPE_____

Occupation____________ Do you have a job?Y/N_____ Are you generally happy with lifeY/N___

Ages of Children_____________________ Are you a caregiver for anyone else?____________

DESCRIBE YOUR NORMAL DAYS OF EATING TO ME:

Breakfast____

Lunch____

Dinner____

Snacks____

PLEASE DESCRIBE YOUR NORMAL DAYS OF FLUID INTAKE TO ME:

Water_____(filtered?) _____Alcohol___________ Coffee/Tea_________

Diet Soda_____ Juice_____ Milk_____ Other_____

How much sleep do you average?_____ Is it sound?_____ What time do you awaken?_____ Do you wake to void?_____ How many times?_____

Do you have urgency?_________ Describe your bowel routine to me__________________________

___X's Daily ___X's weekly, consistency_________Bleeding?_____Pain__

Tell me about your ENERGY Level______________________________

Do you feel stressed?_____ Nervous_____ What do you do when Stressed__________________________

How would you describe yourself emotionally?____

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Are you seeking an MD for anything?

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SurgicalHistory

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List your current medications (Please include birth control & over the counter meds)___________________

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HOW HEALTHY DO YOU FEEL?

What Supplements Do You Take?____

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____________________Did you take them today?______

Do you exercise regularly?___ What type?____________________

Please check any of the following that give you problems with any regularity:

Carb. Digestion	**Fat Digestion**	**Protein Digestion**	**Other issues**
__Airborne Allergies	__ Indigestion	__ Moist Tendencies	__ Dizzy Spells
__Food Allergies	__Dry, Itchy Skin	__Depression	__Blood pressure
__Constipation	__Tired mid-afternoon	__Kidney problems	__Bruising
__Heart weakness	__Sigh frequently	__menstrual concerns	__Mood swings
__Respiratory issues	__High cholesterol	__Menopause issues	__Muscle cramps
__Dry tendencies	__Painful ribs, neck	__Stress incontinence	__Irritable if hungry
__Sore throats	__Tight shoulders	__Water retention	__numb foot/head
_Starch Cravings	__PMS sore breasts	__Back problems	__perspire easily
__Headaches?	__Sore ribs after meals	__Receding gums	__Eyes light sensitive
...where?________	__Difficult to inhale	__TMJ sore jaws	__ringing in ears
__Mouth sores	__Bleeding issues	__Arthritis/Joint pain	__Do you smoke?

Do you crave foods such as salty crunchy, chocolate, paenut butter, starches, alochol, sweets?_______

List other favorite foods____

Why did you come here today?____

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What is the most important issue you would like to have corrected____________________

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Is there anything else I would benefit from knowing about you or your situation?________________

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