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Natural Path to Abundant Health
Let Food be Your Medicine

Natural Paths to ABUNDANT HEALTH FAMILY PRACTICE

NEW CLIENT INFORMATION FORM

CLIENT INFORMATION

NAME:

ADDRESS:

CITY:

STATE: ZIP:

BIRTHDATE: AGE:

GENDER:

MARITAL STATUS: # OF CHILDREN:

EMERGENCY CONTACT: PHONE:

FOR OFFICE USE:
Blood Type:

Geno Type:

◊ Secretor Test — Ordered

Secretor Status:

23 Me:

WEEKLY CHECK-IN:
◊ WEEK ONE
◊ WEEK TWO
◊ WEEK THREE
◊ WEEK FOUR
◊ WEEK FIVE
◊ FOLLOW-UP SCHEDULED

CONTACT INFO

PRIMARY PHONE: TEXT:

SECONDARY PHONE:

E-MAIL: BEST WAY TO CONTACT YOU:

ETHNICITY: Please check what best describes at least 60% of your heritage.
(necessary for food compatibility only)

◊ North Central Asian
◊ African/America
◊ Hispanic
◊ Caucasian/Africa
◊ Caucasian/Asian
◊ African/Asian
◊ Western European
◊ Middle Eastern
◊ Eurasian
◊ Southeast Asian
◊ African
◊ Northern European
◊ Central European
◊ Southern European
◊ Native American
◊ North Africa

MEYERS BRIGGS TYPE INDICATOR: E I N S T F J P =

Who may we thank for your referral or how did you hear about our services?

HEALTH HISTORY

Please explain what brings you here today:

RATE STRESS LEVEL 1-10 (1 = NO STRESS) :

HEALTH CONCERNS:
(Check all that apply)

- ◊ LACK OF ENERGY
- ◊ HEADACHES
- ◊ BACKACHES
- ◊ MUSCLE PROBLEMS
- ◊ HEART PROBLEMS
- ◊ LOW/HIGH BLOOD PRESSURE
- ◊ DEPRESSION
- ◊ POOR APPETITE
- ◊ ALWAYS HUNGRY
- ◊ CANT RELAX
- ◊ GAS
- ◊ BLOATING
- ◊ CONSTIPATION
- ◊ DIARRHEA
- ◊ HIATEL HERNIA
- ◊ HEARTBURN
- ◊ CHRONIC IDEGESTION
- ◊ LOW/HIGH BLOOD SUGAR
- ◊ SEXUAL DYSFUNCTION
- ◊ FEMALE/MALE CONCERNS
- ◊ FREQUENTLY SICK
- ◊ SKIN PROBLEMS
- ◊ COLD HANDS/FEET
- ◊ ALLERGIES
- ◊ INSOMNIA
- ◊ SWOLLEN/PAINFUL JOINTS
- ◊ FOOT PROBLEMS
- ◊ STOMACH PROBLEMS
- ◊ LUNG PROBLEMS
- ◊ KIDNEY PROBLEMS
- ◊ POOR DIGESTION
- ◊ ASTHMA

YOUR HEALTH HISTORY:
(Check all that apply)

- ◊ CANCER
- ◊ HEART or ARTERY DISEASE
- ◊ BOWEL or DIGESTIVE DISEASE
- ◊ URINARY or KIDNEY DISEASE
- ◊ SKIN DISEASE
- ◊ ALLERGY or AUTO IMMUNE DISEASE
- ◊ CHRONIC FATIQUE
- ◊ LOW GRADE INFECTION
- ◊ DEPRESSION
- ◊ LIVER DISEASE
- ◊ THYROID DISEASE
- ◊ DIABETES
- ◊ ARTHRITIS/JOINT DISEASE
- ◊ ENVIRONMENTAL SENSITIVITIES
- ◊ HEAVY MENSES/MENORRHAGIA
- ◊ PREMENSTRUAL SYNDROME
- ◊ PERI-MENOPAUSAL/MENOPAUSE
- ◊ HISTORY OF PROSTATIC ENLARGEMENT
- ◊ HISTORY OF ERECTILE DYSFUNCTION

FAMILY HISTORY:

CANCER OR NEOPLASTA	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
ARTHRITIS or JOINT DISEASE	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
ALLERGY or AUTOIMMUNITY	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
DEMENTIA	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
DEPRESSION or MENTAL ILLNESS	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
DIABETES	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
HYPERTENSION	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
HEART DISEASE	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
THYROID	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS
KIDNEY DISEASE	◊ SIBLING	◊ PARENTS	◊ GRANDPARENTS

LABORATORY RESULTS: *(Check all that apply)*

- ◊ ANEMIA/LOW IRON
- ◊ ELEVATED C-REACTIVE PROTEIN (CRP)
- ◊ LOW PLATLET COUNT
- ◊ HIGH PLATLET COUNT
- ◊ LOW WHITE BLOOD COUNT
- ◊ ELEVATED LIVER ENZYMES
- ◊ ELEVATED GLUCOSE or HgbA1C
- ◊ HIGH CREATININE or BUN
- ◊ HIGH SEDRATE or OXYSTRESS
- ◊ ELEVATED CHOLESTEROL or LDL
- ◊ LOW HDL OR HIGH HOMOCYSTEINE

MEDICATIONS/SUPPLEMENTS

TYPE:	TYPE:	TYPE:
PURPOSE:	PURPOSE:	PURPOSE:
START DATE:	START DATE:	START DATE:
DOSAGE:	DOSAGE:	DOSAGE:

ACTIVITY LEVEL

- ◊ SENDENTARY
- ◊ LIGHT 1-3 Xs PER WEEK
- ◊ MODERATE 3-5 Xs PER WEEK
- ◊ VERY ACTIVE 6-7 Xs PER WEEK
- ◊ ATHLETE—2+ TIMES PER DAY

ACTIVITY TYPE(S):

HEALTH HISTORY CONTINUED

SURGERIES

TYPE:	TYPE:	TYPE:	TYPE:
PURPOSE	PURPOSE	PURPOSE	PURPOSE
DATE:	DATE:	DATE:	DATE:

CHILDHOOD HISTORY

WEIGHT AT BIRTH:

BREASTFED:

DID YOU TAKE ANTIBIOTICS AS A CHILD:

HOW WAS YOUR HEALTH AS A CHILD:

◊ POOR ◊ FAIR ◊ GOOD ◊ GREAT

MOTHER'S OCCUPATION:

FATHER'S OCCUPATION:

LIST ANY SERIOUS ILLNESS OR INJURY AS A CHILD & AGE AT TIME OF EVENT:

SKIN ISSUES: *(Check all that apply)*

◊ ITCHING
◊ ACNE
◊ WARTS
◊ MOLES
◊ ECZEMA
◊ PSORIASIS
◊ ROSACEA
◊ DANDRUFF
◊ OILY
◊ DRY
◊ NAIL FUNGUS
◊ VARICOSE VEINS
◊ BRUISING

ALLERGIES: *(Check all that apply)*

◊ GRASSES
◊ WEEDS
◊ ANIMAL HAIR
◊ ANIMAL DANDER
◊ POLLEN
◊ CHEMICALS
◊ MOLD
◊ FOOD(S)
◊ OTHER(S)

PAIN CONCERNS

LOCATION(S) OF PAIN:

TYPE:
◊ SHARP ◊ DULL ◊ POUNDING ◊ BURSTING

FREQUENCY:

BOWEL ACTIVITY

OF BOWEL MOVEMENTS PER DAY:

TYPE:
◊ SOFT ◊ HARD ◊ LIQUID ◊ PUDDING-LIKE ◊ FORMED

SIZE:
◊ SM ◊ MED ◊ LG

TOXIC EXPOSURE:

MOLD	◊ HOME	◊ WORK	◊ OTHER
CHEMICALS	◊ HOME	◊ WORK	◊ OTHER
MERCURY	◊ HOME	◊ WORK	◊ OTHER
ALUMINUM	◊ HOME	◊ WORK	◊ OTHER
FORMALDEHYDE	◊ HOME	◊ WORK	◊ OTHER
COOKWARE	◊ HOME	◊ WORK	◊ OTHER
EMF / WIFIF / CELLPHONE	◊ HOME	◊ WORK	◊ OTHER
HOUSEHOLD CLEANERS	◊ HOME	◊ WORK	◊ OTHER
PERSONAL CARE ITEMS	◊ HOME	◊ WORK	◊ OTHER
PESTICIDES	◊ HOME	◊ WORK	◊ OTHER
GARDENING CHEMICALS	◊ HOME	◊ WORK	◊ OTHER

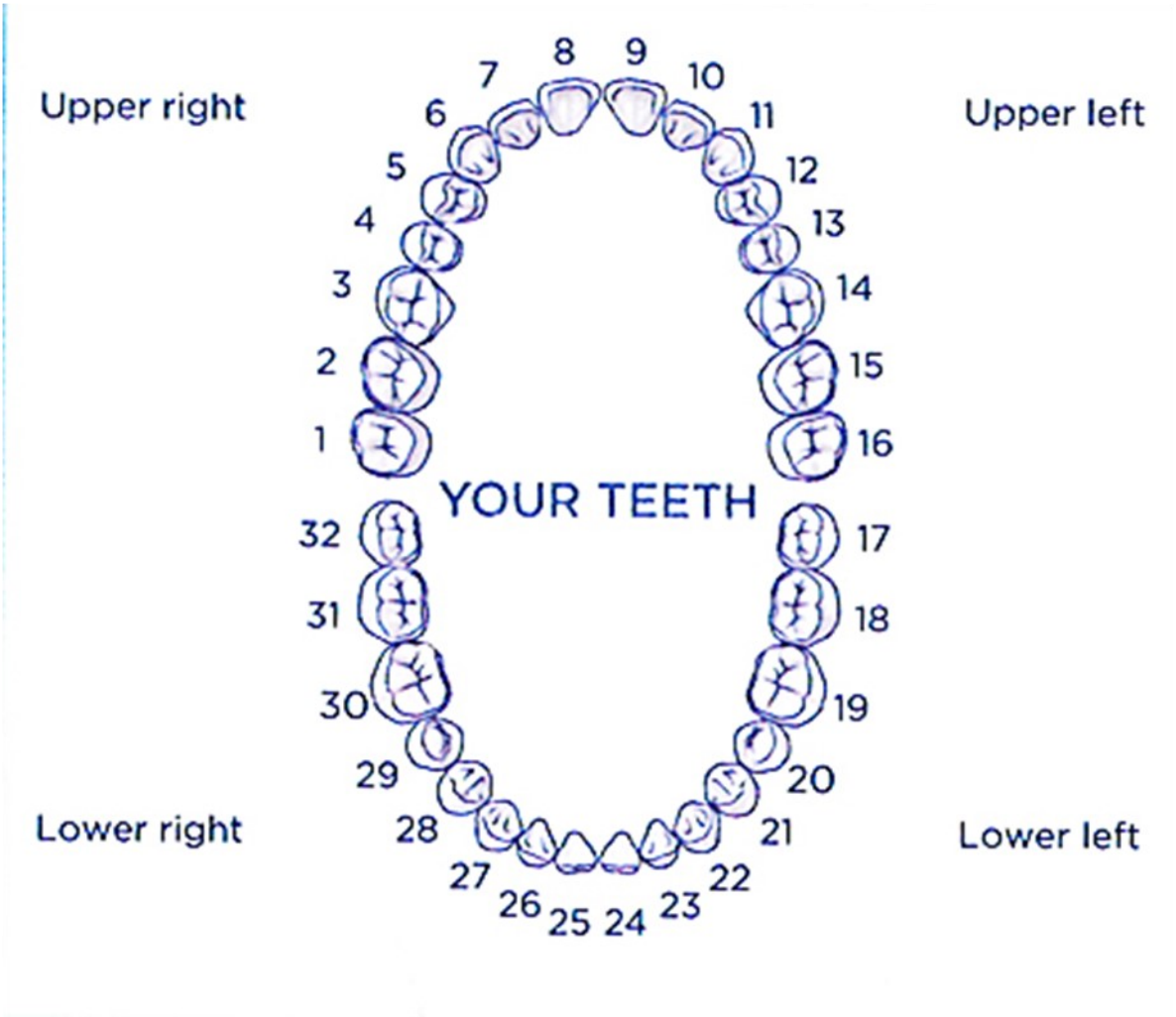
DENTAL HISTORY

DESCRIBE YOUR DENTAL HEALTH IN DETAIL:

You may need the help of a family member or friend to complete this piece.

INSTRUCTIONS: Carefully inspect each tooth and identify any dental work such as filling, cap, root canal, implant, veneer or extraction for each tooth.

In the area below, write the number of the tooth then describe what dental work has been done:



HEALTH HISTORY CONTINUED

NUTRITION

AVG OUNCES OF WATER CONSUMED PER DAY:

TYPE: *(Check all that apply)*

- ◊ CITY
- ◊ WELL
- ◊ PURIFIED
- ◊ DISTILLED
- ◊ REVERSE OSMOSIS
- ◊ SPRING
- ◊ OTHER:

OTHER BEVERAGES CONSUMED:

TYPE: *(Check all that apply)*

- ◊ POP/SODA
- ◊ HOT TEA
- ◊ COFFEE
- ◊ ENERGY DRINKS
- ◊ ICED TEA
- ◊ DIET DRINKS
- ◊ OTHER:

HAVE YOU MADE ANY MAJOR DIET CHANGES IN LAST 4 MONTHS:
IF YES, PLEASE DESCRIBE:

LIST ANY FOODS YOU CRAVE:

ARE YOU CAFFEINE SENSITIVE:

ARE YOU LACTOSE INTOLERANT:

DO YOU USE TOBACCO:

TYPE(S):

FREQUENCY:

DO YOU CONSUME ALCOHOL:

TYPE(S):

FREQUENCY:

ADDITIONAL INFORMATION:

DO YOU GET UP AT NIGHT TO URINATE:
IF YES, HOW OFTEN:

ARE YOU ABLE TO HOLD YOUR URINE:
IF NO, EXPLAIN

ANY DIFFICULTY STARTING A STREAM:

ARE YOU CURRENTLY SEXUALLY ACTIVE:
IF YES, DESCRIBE DIFFICULTIES IF ANY:

WOMEN ONLY:

AGE OF ONSET OF MENSTRATION:
WAS IT PAINFUL:
IF YES, DESCRIBE:

DO YOU EXPERIENCE PMS:
IF YES, DESCRIBE SYMPTOMS:

NUMBER OF PREGNANCIES:
OF MISCARRIAGES:
OF LIVE BIRTHS:
C-SECTIONS:
VAGINAL:

CURRENT METHOD OF BIRTH CONTROL:

DO YOU EXPERIENCE HOT FLASHES:
IF YES, PLEASE DESCRIBE:

ARE YOU MENOPAUSAL:
IF YES, AGE OF ONSET:

HAVE YOU HAD A HYSTERECTOMY:
IF YES, AGE OF PROCEDURE:

HAVE YOU EVER HAD HORMONE REPLACEMENT THERAPY:
IF YES, PLEASE DESCRIBE:

PLEASE READ CAREFULLY:

By signing below I understand that the suggested nutritional program and dietary information is not intended as primary therapy for any disease or symptom. My intention is to find a good nutrition program that will assist me in improving my habits and building a lifestyle that will promote good health naturally. I understand that this dietary health program is not for the diagnosis, cure, mitigation, treatment, or prevention of disease; this is a suggested schedule of nutrients solely provided to upgrade the quality of nutrients in my diet in order to supply good nutritional support for the physiological and biochemical processes of the human body.
I understand that the natural health consultant I am visiting is not a medical doctor and does not treat or diagnose medical conditions; that this is not a replacement for medical counseling; that if I have a medical condition I will seek a qualified medical professional.

I understand that it is my personal decision whether or not to follow the natural health suggestions offered.
I understand it is best to consult my medical doctor when starting any new health care plan.

*Signature*_____*Date*_____