Name:

Address:

Telephone:

Cell:

E-mail:

Reason for consultation:

Profession:

Please list any health concerns:

Please list all medication :

Do you experience any side effects?

Are you taking any supplements, vitamins, herbs etc.?

Are you currently seeing any other health care professionals?:

Please list any injuries – past or present, and cause:

Please list any areas of pain, tension or discomfort in the body:

Please list sources of exercise, sport, or physical activity:

Please list sources of leisure, including hobbies and interests:

Diet:
How would you describe your appetite?

How many:
Meals/day_____
Snacks/day_____
Tea/coffee/day_____
Sweet/salty_____
Meat/fish/eggs/week_____
Fruits/week_____
Vegetables/week_____
Sweets/week_____
Please comment on digestion – constipation, bloating, excess, etc.
Do you drink alcohol?
Do you smoke tobacco?

Sleep:
How would you describe the quality of your sleep?

Quality of rest: do you wake up rested, or still tired?

Do you wake up during the night?

How many hours do you sleep at night?

Please describe the conditions associated with the following:
(if there is nothing noteworthy, leave space blank)

Heart

Breathing

Digestion

Stomach

Liver

Is there anything you feel is important that has not been covered?

Please include a 3 Day Food Diary Prior to your appointment:
Date: Day 1 Date: Day 2 Date: Day 3
Breakfast.. Snack ..Lunch ..Snack ..Dinner.. Snack.. Water

Do not change your eating behaviour at this time, as the purpose of this food record is to analyze your present eating habits.
Record information as soon as possible after the food has been consumed.
Please note all bowel movements as their consistency(regular,loose,or firm)

Signature Date

Please note that the cancellation policy ensures 24 hours warning prior to change, or cancellation of an appointment. Any cancellation effected within the 24 hrs prior the session will be charged at full fee.