Client Information Form

Naturopathic Consultation

Name:____

Address:____
(Street) (City) (State) (Zip Code)

Email: ____ **Phone:**______________________________

Birth date: ____________________________________ **Relationship status:** __________________

Do you have any children? _________ **If yes, what are their names and ages?**_______________________

____

Emergency contact:__________________________________

Your major complaint, or what you would like to work on today? ______________________________

____

____

Please circle what applies from the list below:

Lack of Energy	Asthma	High Cholesterol
Backaches	Low Appetite	Constipation
Headaches	High Appetite	Diarrhea
Muscle Problems	Urinary Concerns	Cold Hands/Feet
Poor Digestion	Sexual Dysfunction	Painful Joints
Heart Problems	Pregnant or Nursing	Frequently Sick
High Blood Pressure	Indigestion	Addictions
Low Blood Pressure	Allergies	Insomnia
Depression	Gas/Bloating	Can't Relax
Anxiety	Menstrual Problems	High/Low Blood Sugar
Panic Attacks	Complexion Concerns	Other: ________________________

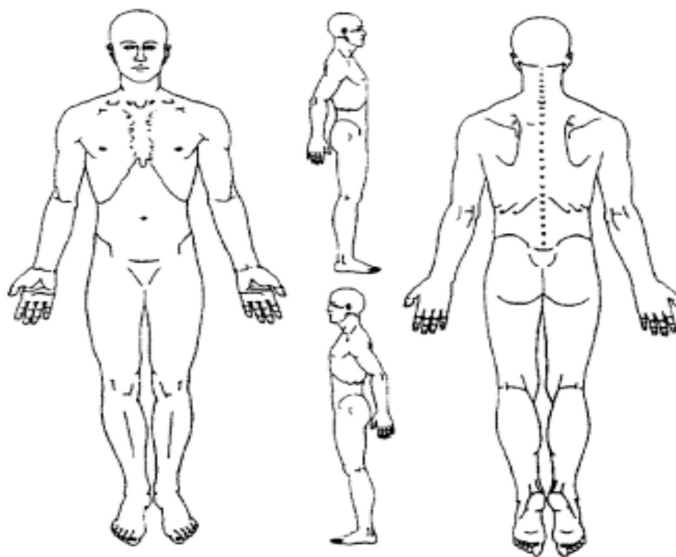
History of trauma/abuse (if yes, circle what applies): Physical Emotional Sexual Spiritual

What has your physician told you about your suspected condition(s):____________________________

____

____

Please circle any areas in which you have discomfort in your body:



Current medication(s) (Either prescribed or over the counter):

Name | What For? | How long have you taken it?

____

____

____

Please list any vitamins, herbs, minerals, or other supplements you take:_____________________________

____

What are the main sources of stress in your life? ____

____

Emotions that you experience most frequently:

Sadness	Grief	Fear	Worry	Joy	Appreciation
Anger	Frustration	Jealously	Envy	Peace	Excitement

Have you ever been in counseling? _________ **If yes, when and for how long?** ___________________________

Self-care practices (ie. yoga, massage, meditation, time in nature, etc.) What kind, and how often:

____

____

Level of exercise (what kind, and how often) ____

____

What time do you go to bed? ____________ **How many hours of sleep do you normally get?**____________

Blood Type: ________________________

Surgeries (Type and Date) ____

____

Accidents / Injuries (Type and Date) ____

____

Any major changes in your diet or lifestyle in the past four months:

Yes No

If yes, please explain: ____

____

____

How often and how much do you:

Consume alcohol? ______________________

Drink soda? __________________________

Drink coffee? __________________________

Use tobacco or cannabis? ________________________

Have food cravings? What foods? _____________________________

How many bowel movements do you have each day? _________________________________

What did you have to eat all day yesterday? ____

____

How many ounces of water/herbal tea do you drink daily? _____________________________________

When was the last time you took antibiotics? ____________ **For what?** ________________________

How many rounds of antibiotics do you estimate you have had over the course of your life? ____________

How did you hear of Continuum Healing? ____

Important:

By signing below, I understand that any information discussed is for educational purposes and any decision that I make is my full responsibility. I understand that my body can only build with the materials I give it. I am aware that I am responsible for my own health and that my daily decisions are key factors to a life of health or a life of disease. I understand that the suggested nutritional/herbal/self-care program will assist me in establishing a lifestyle to build good health and is not a replacement for medical treatment. I understand that this wellness program is not for diagnosis or cure and that any recommendation provided is intended to upgrade the quality of physiological and biochemical processes of the human body. I understand that it is my personal decision whether or not to follow the natural health suggestions offered.

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Cancellation Policy

If you need to cancel an appointment, please do so no later than 24 hours before your appointment. Any no shows or cancellations made with less than 24 hours notice are subject to the full appointment charge. Practitioners retain the right to waive the fee in extenuating circumstances.

Signature: ____ **Date:**__________________________