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Traditional Naturopathy, Shiatsu & Yoga
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CLIENT HEALTH AND LIFESTYLE PROFILE

Date: _____

Name:_____ Date of Birth:_____

Phone:__Home_____ Office _____ Mobile _____

Address _____

Email: _____Referred by: _____

Main problem: _____

Most bothering symptom(s) TODAY (or Most desired improvement TODAY): _____

_____

Today/ present period – on a scale from 1 to 10: Intensity of symptom: ____ Frequency:_____

Family/ Primary relationship status: _____

Type of employment/daily activities: _____

_____

Exercise frequency/type: _____

Diet Summary (more will be discussed during the consultation): Vegetarian: Y/ N

_____

_____

_____

Drinks: water ..... tea..... coffee.....sodas .....other……

Any weight loss diets: Y/ N. If Yes: Which and when: _____

Digestion pattern/ Numbers of daily / weekly bowel movements: _____

--------Women: # of children: ___ Ages _____ Pregnancy problems:_____ Abortions:_____

Last Period:____ Type of period, PMS problems: _____ Birth control: Y/ N

Smoking: N / Y – How much: _____ Since: _____ Alcohol: daily consumption: _____

Medications you are taking _____
Supplements: _____

History of problems & surgeries:

Problem	Year	Solved? How?	Today – still treated? Medications?	Impact on today's life (1 to 10)

Circle/ mark any of the symptoms or physical problems listed below that you are currently experiencing or have experienced in the past. It is important to be very open and honest with your therapist. All the information in this form and any subject discussed during the session will be kept strictly confidential.

Allergies		Fatigue		Arthritis	
Respiratory/Lungs		Weakness		Osteoporosis	
Skin disorders		Numbness		Osteopenia	
		Poor memory		Other musculoskeletal	
Diabetes		Epilepsy		Sciatic pain	
High/Low blood pressure		Emotional disorders (Depression/ Anxiety/ Bi-Polar/ Other)			
Headaches		Speech difficulties		Hearing	
Cardiovascular/ Heart		Dizziness		Vision	
		Insomnia		Contact lenses	
Hormonal imbalance		Stress			
Indigestion		Frequent colds		Cancer	
Flatulence		Other immune system problems			
Ulcer		AIDS		Addictions	
Collitis/ IBS/ Crohn's		Other problem(s):			
Reflux					

Last blood tests date: _____

Family Medical History: Please list the major illnesses or medical conditions of immediate family members (give condition and relationship):

_____
_____
_____
_____

*(continue Family Medical History)*_____
_____
_____

If you have ever seen a natural healthcare professional before, what type, when, and for what reason? _____
_____
_____

I hereby authorize Angie Shapira, MSc., Senior Shiatsu Therapist, Traditional Naturopath, to act as natural health and lifestyle counselor to cooperatively develop a wellness plan to affect my health and wellbeing in a positive manner. I understand that the recommendations given to me in this context are not intended to be prescriptions for my medical condition. Her services are to be considered as an educational and consulting capacity only. I hereby also authorize her to contact any of my other healthcare professionals that she deems necessary to accurately ascertain my medical needs.

To avoid confusing usage of medical language, the term used for the receiver of a naturopathic consultation will be "client" instead of "patient".

Emergency Contact (Name, Phone number): _____

Primary care physician: Name:_____ Phone: _____

Other healthcare professionals (names & contact information) _____

_____ _____

Client Signature Date

We are reserving the time of your appointment solely for you. Please keep your appointment or let us know at least 24 hours in advance if you need to reschedule.

Thank you,

Angie Shapira - Natural Choice For You ™