



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: _____

Your expectations (mark all that applies):

- | | |
|--|---|
| <input type="checkbox"/> Discuss & improve current diet | <input type="checkbox"/> Learn more about natural healthy foods |
| <input type="checkbox"/> Discuss & improve current lifestyle | <input type="checkbox"/> Improve my quality of life |
| <input type="checkbox"/> Find natural alternatives to current medication above | <input type="checkbox"/> Completely cure the main problem |
| <input type="checkbox"/> Other: _____ | |
-

Family/ Primary relationship status: _____

Type of employment/daily activities: _____

Exercise frequency/type: _____

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

How many daily cups of: water herbal tea..... 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)

Mark/ circle any of the symptoms or physical problems listed below that you are currently experiencing or have experienced. 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., ND, CYT, 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™