LAGUNA NATURAL HEALTH

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PERSONAL HEALTH AND LIFESTYLE INTAKE

Name_____ Home Phone_____

Address_____ Work_____

City_____ Cell_____

State_____Zip_____ Fax_____

Email_____

Occupation_____DOB_____

Birthplace_____

Hospital Birth_____ Home Birth_____ Bottle Fed_____ Breast Fed_____

Last date that you used an Allopath (MD)_____

Are you presently under the care of an Allopath?_____

For what condition(s)?_____

_____

_____

_____

_____

List All Current Medications

DRUG	LENGTH OF TIME	DOSAGE

Have/are you currently working with Holistic Practitioners?_____

For what condition?_____

_____

List Current Herbal Remedies, Vitamins and Nutritional Supplements

PRODUCT	LENGTH OF TIME	DOSAGE

What do you want to accomplish by using Naturopathy?_____

_____

_____

What are your major health challenges?_____

_____

_____

_____

_____

What are your goals for your health?

1. _____

2. _____

3. _____

What symptoms or problems are you are presently experiencing?

_____

_____

_____

_____

What three factors most influence your health?

1. _____

2. _____

3. _____

What three factors most influence your diet?

1. _____

2. _____

3. _____

How much time are you willing to devote to your health?

_____

_____

How willing are you to deal with the judgments of your family and those you live with so that you can change your health patterns?

_____

_____

_____

_____

_____

SYMPTOMS: Rate 1-3 in level of frequency, 3 being the most frequent

weight loss/gain	difficulty breathing	confusion
nervousness	muscle tension	itching
muscle cramps	skin rashes	skin boils
cold extremities	headaches	fevers
nightmares	arm problems	earaches
blackouts	ringing in ears	eyestrain
blurred vision	nosebleeds	cough
double vision	mouth sores	fatigue
bad breath	neck pains	cystitis
tongue problems	sore throats	diarrhea
bruise easily	nasal congestion	bone pain
bloody stool	tooth problems	aging fast
gum problems	sinus pressure	dizziness
cough blood	chest pains	back pain
mucous problems	breast pain	breast lump
urinary problems	low endurance	flatulence
shortness of breath	abdominal pain	constipation
hemorrhoids	heart palpitation	bedwetting
blood in urine	swollen legs	joint pain
joint swelling		

Number of daily bowel movements _____

Increased sex drive _____ Decreased sex drive_____

Other (explain)_____

_____

_____

List Allergies_____

_____

_____

_____

_____

_____

_____

_____

FOR WOMEN ONLY: Check appropriate boxes

perimenopausal	hot flashes/night sweats	PMS
menopausal	painful periods	PMDD
postmenopausal	fatigue	are you pregnant now?
heavy flow	# of pregnancies	# of miscarriages/abortions
duration in days	# of children	use of birth control pills
irregular periods	osteoporosis	

Estrogen Dominant: Check appropriate boxes

PMS	menstrual cramps	irregular menstrual periods
heavy menstrual bleeding	bloating	oily skin and hair
fibroid tumors	endometriosis	increased risk of breast cancer
mood swings		

Estrogen Deficiency–Fast Processor: Check appropriate boxes

menopausal	more anxious	wirey
thin and dry skin, hair, tissues	hot flashes	night sweats
insomnia	vaginal dryness	sore joints
rheumatoid arthritis	increased risk for heart disease	increased risk of breast cancer
osteoporosis		

Estrogen Deficiency–Slow Processor: Check appropriate boxes

menopausal	excess weight	difficult time losing weight
fluid retention	thicker bones and connective tissue	beautiful skin and hair
placid temperament	lack of energy	low libido
poor mental acuity	lack of zest for life	osteoarthritis
increased risk of breast cancer	increased risk for heart disease	

FOR MEN ONLY: Check appropriate boxes

andropause	fatigue	change in sex drive
osteoporosis/weak bones	decreased enjoyment in life	loss of height
hair loss	increased upper & middle body fat	changes in mood/attitude
loss of energy	change in agility	decreased muscle mass
back pain	behavioral changes	decreased work performance

What other medical conditions have you experienced?

_____

_____

_____

_____

What surgeries have you had?

_____

_____

_____

Where outside the United States have you traveled in the past 10 years?

_____

_____

List Inoculations/Vaccinations

_____

_____

_____

FAMILY HISTORY

	HEALTHY	CHRONICALLY ILL LIST ILLNESS	DECEASED	AGE
FATHER				
MOTHER				
SISTER				
SISTER				
SISTER				
BROTHER				
BROTHER				
BROTHER				

EATING AND EXERCISE

Describe your appetite_____

_____

_____

_____

How many times a day do you eat any foods?

_____

_____

_____

_____

_____

_____

What type of flavors do you crave? Check appropriate boxes

sweet	salty	spicey
bitter	sour	

EXERCISE

Do you exercise?_____ Times per week _____

Do you have a Trainer?_____ Length of workout_____

Type of exercise(s)_____

_____

_____

EMOTIONAL OBSERVATIONS

Are you in touch with your emotions?_____

Do you sleep well at night?_____ How many hours?_____

What interrupts your sleep?_____

_____

What prevents you from falling back to sleep?_____

_____

_____

Do you frequently dream?_____

Describe_____

_____

_____

What is your favorite season?_____

What is your favorite color?_____

What is your favorite time of day?_____

What is your favorite weather?_____

What do you do when you want to celebrate something?

_____

_____

What do you do when you are very upset?

_____

_____

_____

How do you feel about yourself?

_____

_____

_____

How do you feel about your life?

_____

_____

_____

Reason for Consultation:

_____Nutrition

_____Enzyme Therapy

_____Detoxfication

_____Hormone Health

_____Children's Health

_____Reflexology

Additional Comments

_____

_____

_____

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_____