Heart, Hands and Health

By Grace Galliano

Doctor of Naturopathy

Health History

Client Code:_________________
(to be entered by Staff)

Name____ Date _____________

Street / Apt ____

City / State / Zip ____

EMAIL Address ________________________________ Phone(s)___________________

Date of Birth _________________ Age _____ Sex ____ Height _______ Weight ________

Occupation ____

Were You Referred to Us? If so, by whom? (We'd like to thank them!) _________________________

Please list any conditions you may be experiencing:

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How much sleep do you get on the average? ___________ What time do you go to bed?___________

Do you wake during the night to urinate? ☐ Yes ☐ No How many times? _____________________

Do you have urinary urgency? ☐ Yes ☐ No

How many bowel movements do you have a day? __________

Do you skip days? ____________ How many days do you skip? __________

How is your energy level? ☐ No energy ☐ Low ☐ Moderate ☐ High

What amount of stress do you feel? ☐ Low ☐ Moderate ☐ High ☐ Overloaded

What is causing you stress? ☐ Job ☐ Family ☐ Loss of a Loved One ☐Finances

☐ Other ____

Are you currently being treated by medical doctor? ☐ Yes ☐ No

List surgeries and the year:

Surgery	Year

Do you have your gallbladder? ☐ Yes ☐ No

List medicines, and reason why (Please include birth control pills):

Medicine	Reason for Medicine	How Long

List any nutritional or herbal supplements you are now taking:

______________________ , ______________________ , ______________________

______________________ , ______________________ , ______________________

Do you take medication / supplements diligently? ______________________

List any known or suspected food/plant/herb allergies or sensitivities:

______________________ , ______________________ , ______________________

______________________ , ______________________ , ______________________

Do you exercise? ☐ Yes ☐ No how often? ______________________

What type of exercise? ______________________

What do you normally drink? (check ALL boxes that apply)

Soda, what kind______________________ how much? __________

Coffee: ☐ Regular ☐ Decaf ☐ Drip ☐ Espresso ☐ "Fancy" Coffee House how much? __________

Water: ☐ Tap ☐ Filtered ☐ Bottled ☐ Mineral/Electrolyte ☐ Other __________ how much? __________

Juice/Other, what kind ______________________how much? __________

What foods/sweets do you crave? ______________________

What are your favorite foods? ______________________

How many times a week do you eat your cravings/favorites? ______________________

WOMEN ONLY: How many days is your menstrual cycle? __________

Describe your monthly cycle ______________________

What is your main concern that brought you here today? ______________________

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Disclaimer

- Naturopathic Doctors (NDs) are not Medical Doctors (MDs).
- I understand that I should continue to see any medical doctors I am currently under the care of, and that any prescription medication should not be altered without first consulting the doctor who prescribed it.
- I understand that I may be referred to another member of the health team to seek further care if deemed necessary.
- NDs are trained professionals who use non-invasive natural medicine, such as vitamins, minerals, herbs and dietary changes to create a healthy environment in the body.
- Your visit today is based on the belief that the body has a natural ability to heal itself if given an appropriate internal and external healing environment. Negative comments suggesting disbelief in this philosophy may result in termination of the consultation without a refund.
- Nothing said, done, typed, printed or reproduced by us is intended to diagnose, prescribe, or treat a medical condition, or take the place of a licensed physician.
- Signs of dietary or supplemental deficiency and/or physical or mental stressors may be identified today. Information about traditional uses of supplementation that may create a healthy balance in the body may be discussed. This is not intended as a substitute for a licensed physician's treatment.
- I am not on this visit or any subsequent visit acting as an agent for federal, state, county, or local agencies or news media on a mission of entrapment or investigation.
- Any "sexual" comments or jokes will result in immediate termination of the consultation without a refund.

I have read and discussed the above information and agree with it completely.

Signature ____ Date___________________________

Print Name ____

Parent's signature (if under 18) ____