



Heart, Hands and Health

By Grace Galliano
Doctor of Naturopathy

Health History

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:

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 seeing a medical doctor? Yes No

List surgeries and the year:	Year	Surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 (ND) 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 or denying the fact that you intend to get better will result in immediate termination of the consultation without a refund.
- ◆ Nothing said, done, typed, printed or reproduced by us is intended to diagnose, prescribe, treat or take the place of a licensed physician.
- ◆ Signs of physical, mental, supplemental deficiency or dietary 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 to be interpreted 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) _____