A Living Balance

Date:_____

Name:_____ Best Phone number:_____

Birth date:_____ E-mail address:_____

Height:_____ Weight:_____

Please tell me your major complaint:_____.

_____.

_____.

Other Complaints? _____.

_____.

What are your overall health goals once your complaints are resolved? _____.

_____.

_____.

How long has it been since you really felt good?_____.

_____.

_____.

What are some of the foods that you eat on a daily basis?_____

_____.

Please list foods you tend to overeat or crave (sweets, breads, ice cream, fatty foods, meats etc);_____

_____.

Briefly write about your weight gain/loss history:_____

_____.

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits

b. Was your weight gain/loss:(circle) sudden gradual problem since childhood

What methods have you tried to lose/gain weight?_____

_____.

How is your energy level-scale of 1-10_____Stress Level_____.

How many hours of sleep to you get each night?_____When do you go to bed and wake up_____.

What time of the day do you feel your best _____? Your worst_____?

Please check the box if the question is a "yes" for you.

- ❑ You have chronic aches and pains, such as back and neck pain, headaches or general muscle or joint soreness? (circle which)
- ❑ You take an anti-inflammatory or anti-pain medication, such as ibuprofen, aspirin, or a similar prescription drug for pain, 2 or more times a week?
- ❑ You sometimes experience constipation? How often do you have a bowel movement_____?
- ❑ Your stools are often loose
- ❑ You experience heartburn/acid reflux. How often?_____.
- ❑ You take antacids fairly regularly (at least once a week.)
- ❑ You experience nausea after taking supplements?
- ❑ You sometimes experience bloating, gassiness, indigestion? How frequently_____
- ❑ You are prone to getting hemorrhoids
- ❑ You experience cramping in legs at rest
- ❑ You exercise regularly. Frequency_____ What form of exercise_____
- ❑ You are prone to colds, allergies and flu symptoms
- ❑ You have had a yeast infection. When was the last occurrence?_____
- ❑ You have taken an antibiotic in the past year.

- ❑ You are prone to bladder infections
- ❑ You crave sweets.
- ❑ You have (had) toe/nail fungus
- ❑ You have rash in the groin area
- ❑ You are an anxious eater.
- ❑ When you're feeling down, a snack makes you feel better
- ❑ You sometimes have a hard time going to sleep without a bedtime snack
- ❑ You get tired and/or hungry in the mid-afternoon
- ❑ You get sleepy, almost "drugged" feeling after eating a meal containing bread, pasta, or dessert
- ❑ You find yourself often irritable or angry
- ❑ You tend to put weight on in your middle-abdomen area
- ❑ You find it difficult to lose weight, even with exercising and lowered caloric intake.
- ❑ You find it difficult to keep your weight on.
- ❑ You are a smoker (if yes, how many packs do you smoke per day?)_____
- ❑ You find it difficult to fall asleep
- ❑ You wake up in the middle of the night or the wee hours of the morning and have difficulty falling back asleep.
- ❑ You usually wake during the middle of the night with the need to urinate.
- ❑ You crave carbohydrates
- ❑ You are of Swedish, English, Irish, Welsh, Eastern European decent
- ❑ You have frequent skin rashes, irritations
- ❑ You have/had eczema
- ❑ You have skin breakouts/acne

- ❑ You have restless leg syndrome
- ❑ Your libido has changed in the past few years.
- ❑ Your energy level has changed in the past 6 months to a year.
- ❑ You have experienced heart palpitations
- ❑ You feel less excited about life now than you did 5 years ago?
- ❑ You've had a root canal. When _____

Family History (Includes you)

- ❑ There is a history of depression
- ❑ There is a history of binging and purging
- ❑ There is a history of anorexia.
- ❑ There is a history of high cholesterol
- ❑ There is a history of Heart disease
- ❑ There is a history of Alzheimer's, Parkinson's,
- ❑ There is a history of Cancer in your immediate family. Type_____.
- ❑ There is a history of Diabetes
- ❑ There is a history of Arthritis
- ❑ There is a history of Alcoholism
- ❑ There is a history of Drug addiction (including pain meds)
- ❑ There is a history of Hypertension
- ❑ History of Osteoporosis

1. Do you drink Gatorade, sodas, energy drinks? _____ How many times a week?

2. How often would you say you eat out per week? _____

3. Are you currently under a physician's care_____, Name_____?
   When was the last time that you saw a physician?_____

4. Please list all prescription medications that you are currently taking.
   _____.

5. Please list any supplements that you are currently taking
   _____

6. Do you experience any numbness or tingling in your extremities?_____

7. How many cokes, energy drinks or cups of coffee do you consume per day? _____

8. Do you usually run colder than most of the people around you? _____

9. Is your blood pressure low, high or aver? _____

10. How much water do you typically drink per day? _____

11. What is your blood type?_____

12. Are you a practicing vegetarian_____? Vegan_____?

13. Have you ever had surgery?____ What type_____and when_____.

14. Have you had any dental work in the past 3 years?_____describe_____.

15. Marital Status_____

16. Amount of stress in your personal relationships on scale of 1-10_____.

17. What type of work do you do?_____.

18. Amount of stress related to work on scale of 1-10_____.

19. Are you happy in your life right now?_____

20. How do you deal with your stress**?**_____

21. List at least 3-4 things that you do for fun_____.

_____.

22. How do you relax._____.

23. How many hours of TV do you watch per day_____.

24. How many glasses of wine or cocktails do you enjoy weekly?_____

25. Do you have or have you ever had amalgam(silver) fillings?_____

If you have had them removed, when was that done?_____.

Women Only

26. Is your hair dry or brittle? Are you losing hair?

27. Are you currently taking birth control pills? _____ For how long?_____

28. Do you experience vaginal dryness_____

29. Are your periods normal?_____

30. Do you suffer from PMS?_____What are your symptoms _____

_____.

31. Have your periods change within the last 6 months._____

32. Do you have night sweats?_____

33. Do you sometimes experience incontinence? _____ How frequently?_____.

Informed Consent:

I _____voluntarily consent to be counseled in regards to nutritional supplementation, dietary changes, and possibly lifestyle changes.

I understand and agree that it is important to first consult with a health care professional before beginning to follow any dietary, supplement or exercise program. I understand that taking certain supplements can possibly interfere with some medications and that consulting with my doctor before taking any supplements is recommended In particular, if currently taking psychotropic and/or antidepressant and anti-anxiety medications, or a sleep aid, I understand that I will need to consult, on a regular basis, with my current Doctor, if I decide to take amino acid supplements as they may conflict with or enhance these types of prescription medications.

I understand that Cindy Dupuie, of A Living Balance, may recommend, based on information gathered from the client, supplements to possibly increase over all general well being. Neither Cindy Dupuie, nor anyone affiliated with A Living Balance, claims to diagnose, treat, cure, or prevent any disease nor prescribes any pharmaceutical or medical treatments.

Payment is due at the end of each appointment. You will be responsible for payment of a cancelled appointment if cancellation is made in less than 24 hours from the scheduled appointment.

Signature_____ Date_____