



Intake Data

Name _____ Age _____

Address _____

Telephone (best) _____ Email _____

Reason for visit (prioritized):

1. _____

2. _____

3. _____

Nutritional data:

How many ounces of water/day? _____ What kind? _____

What other beverages and how much? _____

Do you use artificial sweeteners? _____ If so, which ones? _____ How often and in what? _____

Do you eat breakfast? _____ If so, what? _____

How much of the following do you consume? (example: 1D = 1/day, 2W = 2/week, 3M = 3/month)

Fresh fruit _____ Raw vegetables _____ Fermented foods _____

Fast foods _____ Meat _____ Eggs _____ Dairy _____

What do you crave? _____

What foods do you dislike the most? _____

Why? _____

Timing:

What is the first thing you do when you get up in the morning? _____

What time do you eat your first meal? _____ Last meal? _____

Which meal is your largest of the day? _____

Describe a typical largest meal. _____

Movement:

Do you exercise/move/participate in fun sweaty activity? If so, what and how often?

Do you look forward to it? _____
How do you feel when you are finished? _____

Sleep:

What time do you go to bed? _____ How long do you sleep? _____
Do you wake often? _____
If so, why and at what time(s)? _____
Do you feel rested when you wake up for the day? _____
Do you have pain when you first get up? _____ If so, where? _____

Does it go away upon moving? _____

Eliminations:

Do you have daily bowel eliminations? _____ If yes, how many per day? _____
If no, please describe your elimination pattern. _____

Please indicate the most descriptive number(s) of your elimination(s) using the Bristol Stool chart provided. BSC # _____ Color _____

Females:

Are you post-menopausal? _____ If yes, at what age did you enter menopause? _____
What were the characteristics of your menopausal experience? _____

Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? _____
Are you now, or in the near future, planning to become pregnant? _____
Is your menstrual cycle regular? _____ Longer than 28 days? _____ Shorter? _____
Is your flow longer or shorter than 5 days? _____
Do you have cramps or clotting? _____ Would you describe the color of your menses as bright red, dark purple, or brown? _____
Do you experience PMS, cyclical headaches, or cravings? _____

Supplements/medications:

Do you take any supplements? _____ If so, what, how often and why? _____

Do you take any OTC medications routinely (such pain reliver or allergy medicine)? If so, what and how often? _____

Do you take prescription medications (prescribed by a licensed medical professional?) If so, what and how often? _____

Medical history:

Have you had any surgeries? If so, what and when? _____

Have you received any diagnoses from licensed medical professionals? If so, what and when? _____

Naturopathic history:

Have you ever been in consultation with a naturopath? If so, why? How long ago? _____

What was suggested? _____

Did you experience a good outcome? _____

What did you like about it? _____

What wasn't as successful for you? _____

Do you have regular adjustments with a chiropractor? _____

Do you have regular body work/massages? _____

Please check all with which you are familiar:

- Homeopathy
- Bach Flowers/flower remedies
- Probiotics
- Aromatherapy
- Muscle response testing
- Herbals
- Sports nutrition
- Enzymes

I understand that I am here to learn about nutrition and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature _____ Date _____

Bach Flower Consultation:

RBTI Numbers:

Total Carbs

pH

Total Salts

Cell Debris

Ureas

Total Ureas

Eye Findings:

Face Findings:

Tongue Findings:

Nail Findings:

Active MRT Points:

Recommendations:

Next consultation recommended on: