Christine McGrew Blair
Intuitive Naturopath

ADULT New Client - Christine McGrew Blair - (804) 747-3993

www.herbchick.com | feelinggood4life@yahoo.com

DATE OF CONSULT _____ BLOOD TYPE: _____

NAME_____

HOME PHONE# _____ CELL# _____ WORK# _____

ADDRESS_____

_____

E- MAIL ADDRESS _____

DATE OF BIRTH _____ BIRTH TIME:_____ BIRTH LOCATION:_____

AGE _____ SEX_____ HEIGHT_____ WEIGHT_____

OCCUPATION/JOB DESCRIPTION_____

DO YOU LIKE YOUR JOB? _____ ARE YOU INVOLVED IN A RELATIONSHIP? _____

WHAT ARE THE NAMES AND AGES OF YOUR CHILDREN _____

_____

DESCRIBE YOUR USUAL EATING PATTERNS: ****_**BRING FOOD JOURNAL**_****

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

PLEASE DESCRIBE AVERAGE FLUID INTAKE:

Water _____ Alcohol (What Type) _____ Other: _____
Coffee _____ Soda _____
Juice _____ Tea _____

WHAT TYPE OF WATER DO YOU DRINK? _____ OUNCES/DAY _____

HOW MUCH SLEEP DO YOU GET ON THE AVERAGE? _____ IS IT SOUND? _____

DO YOU WAKE TO VOID? _____ DO YOU HAVE URINARY URGENCY? _____

DESCRIBE YOUR NORMAL BOWEL ROUTINE: _____

_____

DESCRIBE YOUR ENERGY LEVEL: _____

DO YOU FEEL STRESSED? _____

Christine McGrew Blair
Intuitive Naturopath

ADULT New Client - Christine McGrew Blair - (804) 747-3993

www.herbchick.com | feelinggood4life@yahoo.com

WHAT DO YOU DO WHEN YOU'RE STRESSED? _____

WHAT ARE YOUR BIGGEST STRESSORS? _____

_____

DO YOU CURRENTLY SEE A MEDICAL DOCTOR (S) FOR ANY REASON? _____

IF SO PLEASE LIST: _____

SURGERIES & DATES _____

_____

PHYSICAL, MENTAL OR EMOTIONAL TRAUMAS YOU HAVE EXPERIENCED…(Attach page if more room is needed)

_____

_____

ARE YOU CURRENTLY TAKING ANY MEDICINES? Why are they prescribed? (Include birth control & OTC Drugs)

_____

_____

PLEASE LIST ANY SUPPLEMENTS YOU ARE NOW TAKING? _____

_____

WHAT TYPES OF EXERCISE DO YOU DO? HOW OFTEN? _____

_____

DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING: *(LIST ADDITIONAL ON BACK)*

___ALLERGIES	___HEADACHES	___JOINT ACHES	___DENTAL
___LEG CRAMPS	___DIZZY SPELLS	___FLUID RETENTION	___HOT FLASHES
___CONSTIPATION	___DIGESTIVE PROBLEMS	___SKIN, HAIR, NAILS	___WEIGHT
___HIGH BLOOD PRESSURE	___NERVOUS TENSION	___MOOD SWINGS	___ LIVER
___DEPRESSION	___DIABETES	___HEART PROBLEMS	___ APPETITE
___KIDNEY PROBLEMS	___BREATHING PROBLEMS	___ SWELLING	___ OBSESSIVE
___HIGH CHOLESTEROL	___ PMS/ MENOPAUSE CONCERNS	___CIRCULATION	BEHAVIOR
___ MENSTRUAL CRAMPS	___ SKELETAL ISSUES	___VARICOSE/SPIDER-VEINS	

ANY ALLERGIES…PLEASE LIST: _____

_____

DO YOU HAVE FOOD CRAVINGS SUCH AS CHOCOLATE, PEANUT BUTTER, BREADS, ALCOHOL OR SWEETS?

_____

WHAT IS YOUR MAIN CONCERN THAT BROUGHT YOU HERE TODAY?

ADULT New Client - Christine McGrew Blair - (804) 747-3993
www.herbchick.com | feelinggood4life@yahoo.com

_____

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE? ***Wellness goals to be written in journal**

_____

Form Revised July 2011 - Subject to change

****PLEASE SHARE FAMILY HEALTH HISTORY***