Lifestyle

Please circle or fill in the appropriate response. Your honest answers will greatly help the evaluation process.

Do you . . .

Exercise adequately? Yes No How many minutes total per week? ____________

What exercise do you do? ____

Sleep well? ________ How many hours per night? ___________ Do you nap? Yes No

Like your work? Yes No How many hours per week do you work? ____________

Are you satisfied with your energy levels? Yes Sometimes No

What would you describe as the two dominant emotions in your life at this time? ______

____

Do you use any of the following on a regular basis?

laxatives coffee tobacco products marijuana aspirin Advil/Tylenol/etc alcohol

Symptom Checklist

Please check any of these symptoms or diseases you have had in the past or present:

______ Difficulty urinating
______ Eyesight problems
______ Incontinence
______ UTI's
______ Bloating
______ Burning urination
______ Nose bleeds
______ High blood pressure
______ Low blood pressure
______ Fainting
______ Chronic fatigue
______ Shingles
______ Swollen glands
______ Earaches
______ Congestion
______ Painful joints
______ Arthritis

______ Diabetes
______ Hypoglycemia
______ Hyperglycemia
______ Too hot
______ Too cold
______ Chest pains
______ Asthma
______ Eczema/Psoriasis
______ Rashes frequently
______ Chemical sensitivity
______ Bruise easily
______ Cancer
______ Seizures
______ Tumors
______ Numbness
______ Night sweats
______ Teeth grinding

______ Hearing issues
______ Poor concentration
______ Depression
______ Loneliness
______ Drug abuse
______ Overly shy
______ Memory loss
______ Frequent crying
______ Overly angry
______ Phobias
______ Bad dreams
______ Alcoholism
______ Constipation
______ Heartburn
______ Frequent gas
______ Nausea
______ Frequent diarrhea

Family History

Has anyone in your family had any of the following? If so, please specify your relation to them.

______ Cancer	______ Asthma	______ Joint disease
______ Diabetes	______ Headaches	______ Low blood pressure
______ Allergies	______ High blood pressure	______ Stroke
______ Heart disease	______ Depression	______ Alcoholism

Do you know your current blood pressure? ____________ Date last taken? __________

Do you have any allergies? Yes No What are they to? ______________________

Headaches

Do you often have headaches? If so, how often? ______________________________

Location/type of headaches - ____

Bowels

Do you have regular bowel movements? Yes No

How many bowel movements do you have a day? _______ How many per week? _____

Is it ever difficult? ____

Men

Please answer only those questions you are comfortable answering.

Do you experience any of the following, past or present?

______ Pain in testicles	______ STD's	______ Vasectomy
______ Dribbling	______ Impotence	______ Low vitality
______ Prostate pain	______ Blood in urine	______ Blood in semen
______ Burning on ejaculation	______ Penis discharge	______ Swelling in testicles

Is it ever difficult to get your urine flowing?

Do you have a steady or interrupted stream of urine?

Do you often have trouble maintaining an erection?

Women: General

Please answer only those questions you are comfortable answering.

Do you experience any of the following, past or present?

______ Breast pain	______ STD's	______ Ovarian cysts
______ Unusual PAP	______ Estrogen therapy	______ Vaginal infection
______ Infertility	______ Fibroids	______ Cesarean sections
______ Live births	______ Vaginal dryness	______ Breast abnormalities
______ Endometriosis	______ Miscarriage	
______ Painful intercourse	______ Abortions	

Women: Menstrual and Menopausal

______	Age at onset	______	Red blood	______	Irritability
______	Clotting	______	Bloating	______	Hot flashes
______	Pain/Cramps	______	Irregular cycles	______	# of days flowing
______	Acne at menses	______	Cycle # of days	______	Flow L M H
______	Regular cycles	______	Brown blood	______	Breast tenderness

Date of last pelvic exam or PAP? ________ Results? ______________________________

Birth Control

Please check all that you have used in the last ten years.

______	Oral contraceptives	______	Diaphragm	______	Fertility Awareness
______	Norplant	______	Morning After Pill	______	Condoms
______	Cervical Cap	______	Depo-provera	______	Spermicidal
______	IUD				

Other ____

Are you currently sexually active? Yes No

Health History

Hospitalizations, when and why? ______________________________________

____

Surgeries, when and why (other than above)? ____________________________

____

Transfusions, when and why? ____

Broken bone(s)? Which one(s)? Date(s)? _________________________________

Head injuries/concussions? When? ______________________________________

Traveled out of the country? When and where? __________________________

Please list major events in the last ten years of your life and the dates they occurred, this includes births, deaths, marriage, divorce, accidents, moves, job changes, miscarriages, illness, and anything else you feel greatly impacted your life.

Dates **Events**

____

____

____

____

____

List any prescription or non-prescription pharmaceuticals you take on a regular basis with amounts and how long you have been taking them. Feel free to use a separate sheet if necessary.

____

____

____

____

List any herbs, supplements or vitamins you take now or took previously on a regular basis. Include dates and amounts. Please bring the bottles with you. Feel free to use a separate sheet if necessary.

____

____

____

____

Are you allergic, or have side effects to any herbs, pharmaceuticals or supplements?

____

____

What are your favorite foods and herbs/spices?

____

____

What foods and herbs do you not like?

____

____

Diet and Nutrition

Your honest answers greatly help the evaluation process. Please list your typical meals including beverages:

Breakfast: Time __________ Beverage ____________________ Good day/bad day?

Snack (mid morning) ____

Lunch: Time __________ Beverage ____________________ Good day/bad day?

Snack (mid afternoon) ____

Dinner: Time __________ Beverage ____________________ Good day/bad day?

Dessert ____

Client Consultations and Consent Form

I understand that I am voluntarily participating as a client for clinical practice and that I am not being charged for this session. I may be asked to fill out a feedback form on this session. I have accurately disclosed my health history and agree to inform my student practitioner if any concerns arise during my session. I understand that this session is not intended to replace medical treatment. I may choose whether or not I wish to implement the suggestions. I release Northern Star College, their employees, and students from any kind of claim.

The personal information that you provide on this Client Information and Consent form will be used to provide you with a student consultation and will also be used as part of the student's education. The student is responsible to keep the information secure and private and to dispose of the information a secure manner..

____
Client Signature

____
Date

____
Student Practitioner Signature

____
Date