Natural Care Center of Woodbury

1740 Weir Drive, Suite 24 Woodbury, MN 55125 (ph) 651-232-6830 (fax) 651-702-2636 www.NaturalCareWoodbury.com

Naturopathic Adult Health Assessment

Patient Name: _____ Age: _____ Sex: M F Date: _____

Please check any medical treatments you may have used:

❑ Acupuncture ❑ Chiropractic ❑ Herbal Medicine ❑ Mind/Body Therapies ❑ Physical Therapy

❑ Biofeedback ❑ Counseling ❑ Homeopathy ❑ Naturopathy ❑ Therapeutic Massage

❑ Other treatments you have received: _____

_____

Living Situation: Married Single Divorced Widowed Children (number): ____ Children's Ages: _____

Prefer relations with: ❑ Male ❑ Female ❑ Male and female

PRIMARY HEALTH CONCERNS:

In your opinion, what are your most important health concerns?

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Others: _____

Is there any condition, trauma, or incident after which you have never been totally well again? _____

_____

On a scale of 1 – 10, how would you rate your current overall state of health? _____

Over the past year has your state of health: ❑ Improved ❑ Worsened ❑ Stayed the Same

Blood Type: A B AB O (+) (-) Unsure?

Ht: _____ Wt: _____ Wt at 20 yr: _____

Over the past year have you gained weight: ❑ Yes (amount): _____ ❑ No

Have you ever been exposed to toxic chemicals, solvents or other possible toxins? ❑ Yes ❑ No If Yes, please explain:

_____

What are your current health goals? _____

_____

_____

_____

HEALTH HISTORY – ADULTHOOD:

Please indicate whether you or an immediate relative has ever had the following diseases or conditions:

Disease	Self	Age at onset	Which Relative? (indicate if deceased-D)
Angina/MI/Heart Attack			
High Blood Pressure			
Stroke			
Blood Clot			
High Cholesterol			
Obesity			
Thyroid Disorder			
Diabetes			
Ulcer, GI Bleeding			
Irritable Bowel Syndrome			
Inflammatory Bowel Disease			
Celiac Disease			
Heartburn/Reflux			
Asthma			
Hay Fever/Allergies			
Tuberculosis			
Emphysema			
Pneumonia			
Eczema			
Psoriasis			
Liver Disease/Hepatitis			
Substance Addiction			
Other			

Disease	Self	Age at onset	Which Relative? (indicate if deceased–D)
Epilepsy/Seizures			
Alzheimer's Disease			
Parkinson's			
Back problems/sciatica			
Headache			
Anemia			
Mononucleosis			
Depression			
Chronic Fatigue			
Fibromyalgia			
Nervous Exhaustion			
Glaucoma			
Macular Degeneration			
Night Blindness			
Arthritis/Rheumatism			
Cancer Specify:_____			
Kidney, Bladder			
Osteoporosis			
Gout			
Injury (serious)			
Venereal Disease (STDs) Specify _____			
AIDS			

HEALTH MAINTENANCE: Please list any significant findings and the date of your last visit for the following exams:

	Significant Findings	Date of Last Visit
Routine Exam		
Pap/Pelvic		
Breast/Mammogram		
Prostate Exam		
Hemoccult		
Flexible Sigmoidoscopy		
Retinal Eye Exam		
Dental Exam		

Describe any dental work done: _____

Describe oral Hygiene practice: _____

HEALTH HISTORY – CHILDHOOD (check all that apply):

- ❑ Measles ❑ Whooping Cough ❑ Diabetes ❑ Mumps ❑ Strep/Tonsillitis
- ❑ Chicken Pox ❑ Polio ❑ Appendicitis ❑ Rubella ❑ Diphtheria
- ❑ Other: _____

At the time of your birth, did you experience any unusual birth trauma: ❑ Yes ❑ No

PSYCHOLOGICAL:

How would you rate your overall level of stress (with 1 being No Stress, and 10 being Unbearable Stress)?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

What types of things cause you stress? _____

_____

What symptoms of stress have you experienced? _____

_____

Please list any significant stressors you have experienced (e.g., accidents, divorce, death, change or loss of job, or ending of relationship):

Type of stressor:	Month/Year:

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NATUROPATHIC INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

I, _____, hereby consent to outpatient naturopathic care at the Natural Care Center of Woodbury.

I understand that:

1. Amrit Devgun, ND is fully credentialed and registered to practice naturopathic medicine in the State of Minnesota, pursuant to Minnesota Statute 147E. Her active registration number is 1004 with the Minnesota Board of Medical Practice. She received her naturopathic medical training at the Canadian College of Naturopathic Medicine and graduated in 1995.

2. The scope of practice of a registered naturopathic doctor in the State of Minnesota includes, but is not limited to, the following services: (a) ordering, administering, prescribing, or dispensing for preventive and therapeutic purposes: food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, botanical medicines, herbal remedies, homeopathic medicines, dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, glandulars, protomorphogens, lifestyle counseling, hypnotherapy, biofeedback, dietary therapy, electrotherapy, galvanic therapy, oxygen, therapeutic devices, barrier devices for contraception, and minor office procedures, including obtaining specimens to assess and treat disease; (b) performing or ordering physical examinations and physiological function tests; (c) ordering clinical laboratory tests and performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1988 (CLIA); (d) referring a patient for diagnostic imaging including x-ray, CT scan, MRI, ultrasound, mammogram, and bone densitometry to an appropriately licensed health care professional to conduct the test and interpret the results; (e) prescribing nonprescription medications and therapeutic devices or ordering noninvasive diagnostic procedures commonly used by physicians in general practice; and (f) prescribing or performing naturopathic physical medicine; (g) admitting patients to a hospital if the naturopathic doctor meets the hospital's governing body requirements regarding credentialing and privileging process.

3. A registered naturopathic doctor is not allowed to: (a) administer therapeutic ionizing radiation or radioactive substances; (b) administer general or spinal anesthesia; (c) prescribe, dispense, or administer legend drugs or controlled substances including chemotherapeutic substances; (d) perform or induce abortions; or (e) perform surgical procedures using a laser device or perform surgical procedures beyond superficial tissue.

4. A registered naturopathic doctor is not allowed to practice or claim to practice as a medical doctor, surgeon, osteopathic physician, dentist, podiatrist, optometrist, psychologist, advanced practice professional nurse, physician assistant, chiropractor, physical therapist, acupuncturist, dietician, nutritionist, or any other health care professional, unless the naturopathic physician also holds the appropriate license or registration for the health care practice profession.

5. Potential risks include allergic reactions to prescribed herbs and supplements and side effects of natural medications.

6. All female patients must alert the provider if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy. All individuals with bleeding disorders, pacemakers, and/or cancer must also alert the provider.

7. I understand that the treatment suggestions provided are not all accepted by the United States FDA and therefore should not be taken as such. I understand
that treatment options and recommendations will be presented as accurately as possible and according to standards of good naturopathic medical practice.

8. I further consent to the performance/interpretation of those diagnostic procedures, examinations and rendering of treatment by the provider(s) and their assistants, including their designees as is necessary in the provider(s)' judgment. The provider or any of the personnel has given no guarantees to me concerning the results intended from the treatment.

9. With this knowledge, I voluntarily consent to the above procedures. I understand that this consent form will be valid and remain in effect as long as I receive naturopathic medical care at the Natural Care Center of Woodbury. I understand that I am free to withdraw my consent and to discontinue participation in
these procedures at any time.

*PATIENT PLEASE REVIEW * PRINT & SIGN NAME*

I acknowledge that I have been provided ample opportunity to read or have read to me this informed consent document. I have been given the opportunity to discuss any questions or concerns with my provider and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

☐ By checking this box, I consent to information about myself, or my minor, being left via voicemail.

Patient Name (print)_____ Date of Birth_____

_____ _____ _____ _____
(Patient/Guardian Signature) (Date) (Translator/Interpreter Signature) (Date)

Clinician Only

Based on my personal observation, the patient's history and physical exam, I conclude that throughout the informed consent process the patient was:

- ☐ Of legal age or Consent given through guardian
- ☐ Appears unimpaired
- ☐ Oriented X3
- ☐ Fluent in English Assisted by a translator/interpreter

_____, ND _____
(ND Signature) (Date)

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PATIENT FINANCIAL ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgements, then sign and print your name and the date. Thank you.

VERIFICATION OF BENEFITS

☐ If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **YOU** contact your insurance company **PRIOR to your first visit in our office**. We are happy to answer any insurance questions you may have, but please understand, The Natural Care Center can only assist you and **CANNOT** guarantee payment from your insurance company. Please note that it is your responsibility to understand your insurance benefits and coverage. Giving the Natural Care Center all of your insurance information, including any secondary insurances, will help us to **estimate** your benefits to the best of our ability.

ASSIGNMENT OF BENEFITS

☐ I assign all benefits payable to me for my care at the Natural Care Center of Woodbury. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

☐ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. I acknowledge that any exams not covered by insurance are due in full at the time of service. Your initials are a guarantee of payment for all charges incurred for treatment in accordance with the rates and terms of this health care facility. In the event that you have insurance coverage for chiropractic care and your diagnosis, but have an unmet deductible, the clinic may use the insurer's provided fee schedule to calculate your owed amount and collect a portion, or all, of your fee up front. In the event that payment cannot be made on the account and it is sent to collections, a 35% fee will be added to cover the cost of the collections agency. In the event that the clinic must take legal action against any persons with an outstanding debt, the patient is responsible for all legal and attorney fees.

APPOINTMENT FEES AND CANCELLATION POLICY

☐ We require a **$50 deposit** on all new patient chiropractic, acupuncture and massage appointments to secure your time; naturopathic appointments require **a full amount deposit**. This will be applied to your appointment/account or refunded if insurance pays in full for services. **We require a 48-hour cancellation notification** for our Acupuncture/Oriental Medicine, Massage, and Graston Therapy appointments; **we require one business weeks' notice for naturopathic appointment cancellation**. Please note: **a $50 fee will be assessed for acupuncture and massage, and a $25 fee for Graston cancellations made with less-than 24-hour notice, and the full deposit amount will be forfeited for naturopathic appointments without proper notice.** Monday appointments must be cancelled on the Thursday prior to your scheduled visit to meet the 48-hour window.

ACUPUNCTURE COVERAGE

☐ Your initial Acupuncture exam may, or may not, be covered. Please check with your insurance carrier about your specific plan and condition to ensure coverage. Even if your health plan covers general Acupuncture, your specific diagnosis may not be covered for treatment. If this is the case, you must pay out-of-pocket, but at a discounted rate for Acupuncture.

FOR ACUPUNCTURE AND CHIROPRACTIC **MEDICARE** PATIENTS

☐ **Acupuncture is not a covered** service since licensed Acupuncturists are not able to credential with Medicare. We are not able to submit claims to them at any time. Also, **Chiropractic examinations and re-examinations are never covered** by Medicare. Your provider must do these to provide you with safe, accurate care even though they are not covered by the insurance. Medicare also **does not cover therapies such as electric muscle stimulation, ultrasound, or traction. Please note:** Medicare is your primary insurance carrier; this means that your supplement plan or secondary coverage will not pay the cost of these services even though they cover them. They only pay any additional costs after your primary insurance pays its portion.

_____ _____ ____/____/____

SIGNATURE (PATIENT/GUARDIAN) **PRINT NAME** **DATE**

Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good **Relaxation** ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name_____ Date_____

Food Plan Type: _____

Day 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good Relaxation ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

IFM

Diet, Nutrition, and Lifestyle Journal – 3 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P _____ F _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐ Poor ☐ Fair ☐ Good **Relaxation** ☐ Yes ☐ No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

IFM

Ayurvedic VPK Prakruti Questionnaire

Please highlight/circle your answer for each row. Answer each question thinking about how you have been **over the years**, your tendencies, your 'always have been' statements. Do not chose your answer based on just the last 3-4 months. Total your responses at the end.

Personality/Mind

Flexible, optimistic	Ambitious, intense, practical	Calm, peaceful, complacent
Lively, full of life, intuitive, highly active; fast paced, fast motions & fast paced	Motivated, warm, perceptive, intense, determined; active, medium paced	Resilient, content, easy going, loyal, slow & steady, tend to be inactive/slow; need motivation
Enthusiastic, changeable	Friendly, independent, risk taker	Deliberate, relaxed, compassionate
Anxious, insecure, scattered, fearful, moody, emotional and tense esp when under stress	Aggressive, angry, argumentative and irritable esp when under stress; others want more tolerance from me	Lethargic, dull, in denial, indifferent and tend to withdraw esp when under stress; slow to get angry
Initiator	Leader, goal oriented, competitive	Patient, nurturing, stable
Speech: fast, talkative, excessive, imaginative	Speech: precise, convincing, clear, detailed, organized	Speech: slow, monotone, melodic & soothing voice
Memory: quick to learn but quick to forget (good short-term)	Memory: average, clear, distinct (good overall)	Memory: slow to learn but slow to forget (good long-term)
Thoughts: restless, quick, many	Thoughts: organized, efficient, accurate	Thoughts: slow, methodical, deliberate
Process information quickly	Process information at average speed	Process information slowly
Multitasker; enjoy more than 1 thing at a time; may not follow through to completion	Inventive in many areas with good follow through; focus sharply on projects until complete	Can only focus on one thing at a time until complete; methodical and in no hurry
Indecisive	Quick and decisive	Deliberate in making a decision
Learn by listening	Learn by reading or visual aids	Learn by association with another memory
Tendency to question and theorize	Tendency to be judgmental or artistic	Tendency to be stable and logical
Sensitive to noise	Sensitive to bright lights	Sensitive to strong odors
Gait: quick short steps	Gait: medium paced, purposeful	Gait: slow and graceful
Energy comes in short spurts; I want to push myself and then need to rest	Energy is moderate to high; I tend to push myself	Long lasting, good energy
Tend to make friends easily; easily adapt to different kinds of people	Tend to choose friends on the basis of their value	Slow to make new friends but forever loyal
Enjoy travel, art, esoteric subjects	Enjoy sports, politics, luxury	Enjoy good food
Can't save money, spend on trifles, can be wasteful	Spend moderately, can save but ok spending on luxuries	Thrifty spending habits, good at saving; can spend on good food

SubTotal _____ SubTotal _____ SubTotal _____

Physical Aspects

Fast eater	Moderately fast eater	Slow eater
Perspiration: scanty, no odor	Perspiration: heavy with strong odor	Perspiration: moderate, sweet odor
Appetite: irregular, can forget to eat	Appetite: strong, must eat regularly	Appetite: constant but can skip meals
BMs: dry, hard, constipation	BMs: soft, oily, loose	BMs: heavy, slow, thick, regular
Sleep: light and interrupted	Sound and even sleep	Long and deep; difficult to wake up
Small, prominent bones & frame	Medium bones & frame	Large, heavy bones & frame
Thin as a child	Medium build as a child	Large, heavy build as a child
Above or below average height	Average height	Average to tall height
Long, tapering fingers and toes	Fingers, toes medium length	Fingers, toes short/square
Lose weight easily	Lose and gain weight easily	Gain weight easily
Weight gain - waist	Weight gain - evenly	Weight gain - hips/thighs
Dark complexion compared to others of my ethnicity; tan easily	Red, freckled, yellowish complexion compared to others of my ethnicity; sunburn easily	Light or pale complexion compared to others of my ethnicity; tan evenly
Skin: dry, thin, rough and cold; cold hands and feet	Skin: delicate, sensitive, warm to touch	Skin: oily, thick, smooth, soft; cool
Skin chaps easily, prone to calluses	Skin prone to pimples & rashes, oily	Thick skin, well lubricated
Hair: dry, brittle, thin, coarse, lusterless; curls/wavy, brown, black	Hair: fine, light, straight, red; early graying, thinning or balding	Hair: thick, slightly wavy or curly, dark brown or black, lustrous
Scant or abundant body hair; dark, coarse, curly	Scant body hair, fine texture	Moderate body hair; thick hair
Forehead: small	Forehead: medium	Forehead: large
Eyes: small, dark, active; dry; white of eye gray or blue tinge	Eyes: medium; white of eye reddish or yellow tinge	Eyes: large; tend to be puffy
Eyebrows: thin, dry	Eyebrows: medium	Eyebrows: thick, large, bushy
Lips: crack and tend to chap often	Lips deep red and tendency to cold sores and fever blisters	Full moist lips
Teeth: crooked, protruding; receding & sensitive gums	Teeth: medium, even, yellowish; tender gums	Teeth: large, strong, white; healthy gums
Nose: small, thin, uneven	Nose: long and pointed	Nose: short, rounded, thick
Muscles: underdeveloped	Muscles: moderately developed	Muscles: stocky, well developed
Hands: cool and dry	Hands: moist and warm	Hands: oily and cool
Prefer warm weather; dislike cold and dry wind	Prefer cool days; dislike heat and strong sun	Prefer moderate days; dislike cool and damp/humid
Libido: frequent, either high or low	Libido: moderate; passionate, intense	Libido: infrequent, loyal, romantic

SubTotal _____ SubTotal _____ SubTotal _____

Total (pg 1&2) _____ **Total (pg 1&2) _____** **Total (pg 1&2) _____**

NAME: **DOB:** **DATE:**

Please highlight/circle the most applicable response.

NUTRITION

Do you follow a specific food plan? If yes, what closely matches?	Vegetarian/ Vegan	Lacto-ovo-Vegetarian	Pescetarian Plant-Keto Other	Carnivore Meat-Keto Paleo
Do you have food intolerances?	Never	Occasionally	Daily	Chronic
Do you use the following oils for **cooking**?	Olive Avocado Ghee Coconut	Butter	Lard	Canola Vegetable Oils
Do any of these apply to you: don't enjoy healthy food, don't like vegetables, don't know how to cook, lack of time to cook, rely on frozen/canned foods, live alone, no interest in food.	1-2X/mo	1-2X/wk	2-3X/wk	Daily
How many meals do you generally eat each day?	3	2	1	4+
Which is your main meal of the day?	Lunch	Breakfast	Snacks	Dinner
How often do you skip meals?	Never	1-2X/month	More than 1X/week	Daily
How often do you eat freshly cooked home made meals?	Daily	5-6X/wk	2-3X/wk	Less than 2X/wk
What is the maximum number of days you eat leftovers?	Eat fresh daily	Up to 24 hrs	2-3 days	4+days
How many times per week do you pick up, eat frozen entrees or dine out?	1-2X/mo	1-2X/wk	More than 1X/wk	Daily
On average, how many servings of alcohol do you drink per day?	0	1-2/wk	1/day	2+/day
On average, how many cups (8 oz.) of sugary drinks (juice, soda, sports drinks, 'healthy' drinks with added sugar) do you drink per day?	0	1-2/wk	1/day	2+/day

Do you use natural or artificial sweeteners on a daily basis? (i.e. Equal, Stevia, Splenda, Sweet & Low, honey, agave, etc.)	0	1-2X/wk	1X/day	2+X/day
On average, how often do you snack on convenience, non-whole real food (even if marketed as 'healthy')or "junk" food per day,? (i.e. chips, candy, granola bars, protein bars, crackers, cookies, etc.)	0	1-2X/wk	1X/day	2+X/day

HYDRATION

On average, how many 8 oz glasses of water do you drink per day?	6+	4-5	2-3	0-1
Do you drink to thirst or more or less than thirst?	Thirst	Because I think it's healthy	More	Less
What type of water do you drink?	Filtered	Spring	Well	Tap
What temperature of water do you drink?	Warm/hot	Room temp	Cold	With ice
Do you drink beverages with meals?	A few sips	No		Yes
On average, how many cups (8 oz.) of caffeinated beverages do you drink per day (tea, soda, coffee, or energy drinks)?	0	1/day	2-3/day	4+/day

FITNESS

Do you have a regular fitness program?	Yes			No
During the average week, how many **days** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough to break a light sweat)?	5-7X/wk	3-4X/wk	1-2X/wk	Less than 1X/wk
During an average session, how many **minutes** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough movement to break a light sweat)?	30 min	15 min	5 min	I don't
What kinds of exercise do you do?	Stretching	Cardio	Weights	Extreme
What motivates you to exercise?	Overall	Particular	Family	Body

	well being	health issue		image
Do you have any injuries that would make it difficult to exercise?	No			Yes
Do you have any joint, muscle, or bone problems that might get worse with exercise?	No			Yes
Do you have any breathing problems while exercising? If yes, please explain:	No			Yes

SLEEP

I sleep like a baby!	Yes			No
Do you feel rested when you wake up for the day?	Yes	Takes a few min	Takes 30 - 60 min	1-3 hrs
How many hours of sleep do you get for the night?	8 hrs	7-8 hrs	6 hrs	Less than 6 hrs
How often do you go to bed and wake up around the same time daily?	Daily	5-6X/wk	2-3X/wk	Less than 2X/wk
Do you use sleep aids of any kind?	No	1-2X/mo	1-2X/wk	3X or more/wk
How often does it take you more than 30 minutes to fall asleep at night without any supplements?	1-2X/mo	1-2X/wk	2-3X/wk	Daily
Do you need/take naps during the day? If so, how long?	None	10-15 min	15-30 min	30+ min
How often do you wake up in the middle of the night?	1-2X/mo	1-2X/wk	2-3X/wk	Daily
How often do you wake up earlier in the morning than you'd like?	1-2X/mo	1-2X/wk	2-3X/wk	Daily
Do you sleep in the dark or with some source of light?	Dark			Light
When do you shut off electronics before going to sleep/closing your eyes?	2 hrs	1 hr	30 min	Right before
Do you have restless legs, feel too hot or cold, sweating at night?	Rare	1-2X/wk	2-3X/wk	Daily

DIGESTION

How often do you eat just to stomach hunger?	All meals	80% daily meals	50% daily meals	Rarely
Do you feel hungry in the morning and before eating?	Yes	Somewhat		No
Do you have any strong craving or aversions to any foods?	No			Yes
Do you have any strong reactions to any foods?	No			Yes
What is your speed of eating as compared to others?	Avg		Slow	Fast
Do you feel bloating, gassy, uncomfortable, indigestion, need for a bowel movement during/after eating?	1-2X/mo	1-2X/wk	2-3X/wk	Daily
How many bowel movements do you have?	1-2X/day	5-6X/wk	3-4X/wk	Less than 3X/wk
Do you have a bowel movement within ½ hr after waking?	Daily	5-6X/wk	2-4X/wk	Less than 2X/wk
Do you need any kind of laxative to have a bowel movement?	1-2X/mo	1-2X/wk	2-3X/wk	Daily
What do your bowel movements generally look like?	Long, formed	Dry lumps but long	Small pellets	Loose pile

ENVIRONMENT

How often are you exposed to strong chemical smells from bath and beauty products (fresh nail polish, hairsprays, perfumes, etc)?	1-2X/mo	1-2X/wk	3-4X/wk	Daily
How often are you exposed to any of the following: pesticides, herbicides, fertilizers, cleaning chemicals, new carpet, paint, air fresheners,	1-2X/mo	1-2X/wk	3-4X/wk	Daily
Do you live near or often are around a busy street, golf course, city parks or other areas treated with pesticides, herbicides, etc?	1-2X/mo	1-2X/wk	3-4X/wk	Daily
Do you use nonstick cookware?	Rare/no	1-2X/mo	1-2X/wk	Daily
Do you heat food or pack hot food in plastic containers?	Rare/no	1-2X/mo	2-3X/wk	Daily
Are you exposed to smoke?	Rare/no	1-2X/mo	2-3X/wk	Daily

DAILY ROUTINE

Do you follow a daily routine for sleep/wake cycles, meals, and fitness?	Daily	5-6X/wk	1-2X/wk	No
Do you practice any ayurvedic oil routines?	Daily	5-6X/wk	1-3X/wk	No
Do you delay/suppress urges (bowel movements, urination, hunger, thirst, sneezing, cough, yawning, burping, gas, sleeping, emotions, libido)	1-2X/mo	1-2X/wk	2-3X/wk	Daily

Do you travel a lot?	Rare	2-3X/yr	4-5X/yr	6+X/yr
Do you eat while watching TV, driving, walking, standing, having a lot of conversation?	1-2X/mo	2-3X/wk	4-5X/wk	Daily

BREATHING

Do you practice any breath work?	Daily	4-6X/wk	1-2X/wk	Rare/No
How often do you find yourself letting out sighs?	1-2X/wk	3-4X/wk	Daily	Throughout the day
How often do you find yourself yawning even when you are not sleep deprived?	1-2X/wk	3-4X/wk	Daily	Throughout the day
Do you feel so restless that it's hard to sit still?	1-2X/mo	2-3X/wk	Only certain time of day	Throughout the day

MEDITATION

Do you have a meditation practice?	Daily	4-6X/wk	1-2X/wk	Rare/No
Do you notice stress in your body or mind regardless of circumstances?	Rare/No	Sometimes	Often	Always
Do you notice stress in your body or mind in stressful circumstances?	Rare/No	Sometimes	Often	Always
Do you experience a quiet mind?	Often			Rare/No

PURPOSE/CONNECTION

Do you look at challenges as opportunities for growth?	Always	Often	Sometimes	Rare/No
Do you find purpose in your life?	Always	Often	Sometimes	Rare/No
Do you feel motivated to meet the goals you set for yourself?	Always	Often	Sometimes	Rare/No
Do you find it easy to prioritize self care?	Always	Often	Sometimes	Rare/No
Do you feel lonely regardless of your social circle?	Rare/No	Sometimes	Often	Always