Nourishing Journey

Initial Wellness Consultation Form

Family History

MOTHER

Age/ Age at Death	Illnesses/ Conditions/ Diseases

MATERNAL GRANDPARENTS

Age/ Age at Death	Illnesses/ Conditions/ Diseases

FATHER

Age/ Age at Death	Illnesses/ Conditions/ Diseases

PATERNAL GRANDPARENTS

Age/ Age at Death	Illnesses/ Conditions/ Diseases

SIBLINGS

Age/ Age at Death	Illnesses/ Conditions/ Diseases

Possible Toxin Exposure

Check if you have ever had an exposure and include dates and known reactions on back of page if pertinent.

***** Please include a full list of vaccinations, dates given and any possible reactions *****

- ☐ Silver/Metal Fillings
- ☐ Vaccinations
- ☐ Medications
- ☐ Antibiotics
- ☐ Pesticides
- ☐ Known Lead
- ☐ Known Mercury
- ☐ Known Other Heavy Metals
- ☐ Smoke or drink alcohol
- ☐ Eat or drink from plastics
- ☐ Use microwave
- ☐ Eat non-organic or GMO foods
- ☐ Eat foods with food coloring, flavoring or preservatives
- ☐ Drink tap water with no filtration
- ☐ Eat at restaurants more than once per week
- ☐ Exposure to fuel other than filling up car tank
- ☐ Exposed to man-made chemicals or waste
- ☐ Live near a dump
- ☐ Travel in airplane often
- ☐ Bleach or other harsh cleaning chemicals
- ☐ Non-organic body care products

Health History

Please check all that are appropriate and fill in pertinent information to the right of the item. Use the back of the page if you need more room. If you have relevant medical reports, please include those as well.

- ☐ Dental Work _____
- ☐ Surgery _____
- ☐ Cancer _____
- ☐ Chronic Fatigue _____
- ☐ Depression/Bipolar _____
- ☐ Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Parasites _____
- ☐ Lyme Disease _____
- ☐ Yeast/Fungal _____
- ☐ Liver Disease _____
- ☐ Kidney Stones _____
- ☐ Gallstones _____
- ☐ Constipation _____
- ☐ Diarrhea _____
- ☐ Bowel Disease _____
- ☐ Indigestion/Reflux _____
- ☐ Skin Condition _____
- ☐ Kidney Disease _____
- ☐ Thyroid Problems _____
- ☐ Adrenal Problems _____
- ☐ Stroke/Seizure _____
- ☐ Arthritis/Gout _____
- ☐ Heart Condition _____
- ☐ High Cholesterol _____
- ☐ Low Cholesterol _____
- ☐ High/Low BP _____
- ☐ AIDS/Hepatitis _____
- ☐ Allergies _____
- ☐ Weak Immune _____
- ☐ Auto-Immune _____
- ☐ Autism/ADHD _____
- ☐ Other Behavioral _____
- ☐ Other Neurological _____
- ☐ Addictions _____
- ☐ Other Concerns _____

Hospitalizations or Illnesses not mentioned above? Please circle all that apply.

Measles	Mumps	Thyroid Disease
Scarlet Fever	Whooping Cough	Chicken Pox
Rheumatic Fever	Pneumonia	Pleurisy
Tuberculosis	Influenza	Arthritis
Typhoid Fever	Diabetes	Cancers
Kidney Disease	Heart Disease	Other: _____

Symptoms

Please check any symptoms from which you currently suffer.

HEAD
____Migraine Headache
____Sinus Headache
____Other Headaches
____Convulsions
____Fainting
____Stroke

NOSE
____Nosebleeds
____Dryness
____Obstructions
____Chronic Congestion
____Snoring
____Other: _____

EYES
____Light Sensitivity
____Blurred Vision
____Loss of Vision
_ Cataracts
____Glaucoma
____Other:_____

EARS
____Hearing Loss
____Deafness
____Discharge
____Ringing
____Dizziness
____Chronic Infection

SKIN
____Acne
____Itching
____Psoriasis
____Sores/ Blisters
____Eczema
____Eruption/ Ulcer

MOUTH/THROAT
____Swollen Glands
____Bleeding Gums
____Sore or Hoarse
____Coughing Blood
____Recurring Colds
____TMJ syndrome

BREAST
____Lump or Mass
____Tenderness
____Cystic Mastitis
____Nipple Discharge
____Fibroids
____Cancer

LUNGS
____Chronic Cough
____Sputum Production
____Shallow Breath
____Chest Congestion
Date of
Last X-ray _____

MUSCULOSKELETAL
____Muscle Weakness
____Joint Stiff/ Pain
____Tenderness
____Numbness
____Paralysis
____Spasms

ENDOCRINE
____Weight Gain
____Excessive Thirst
____Cold Extremities
____Excessive Hair Loss
____Excessive Urination
____Sudden Weight Loss

GENITOURINARY
____Frequent Urination
____Difficult Urination
____Infrequent Urination
____Incontinence
____Flank Pain
____Kidney Stone
____Discharge/ Burning

GENERAL
____Fatigue
____Anxiety
____Insomnia
____Depression
____Stress
____Other: _____

HEART/CIRCULATORY
____Chest Pain
____Angina
____Palpitations
____Heart Attacks
____Shortness of Breath
____Short of Breath at Night
____High Blood Pressure
____Low Blood Pressure
____Spider Veins
____Varicose Veins
____Bruising Easily
____Calf Pain
____Swelling/ Edema
____Other: _____

GASTROINTESTINAL
____Loss of Appetite
____Chronic Indigestion
____Chronic Heartburn
____Bloating after Meal
____Jaundice
____Nausea/ Vomiting
____Excess Gas
____Diarrhea
____Abdominal Pain
____Constipation
____Hemorrhoids
____Rectal Bleeding
____Light Stool
____Black/ Tarry Stool

MEN
____Decreased Desire
____Loss of Erection
____Fertility Issues
____Prostate Issues
____Testicular Issues
____Other: _____

WOMEN
____Age of 1st /Last Period
____Abnormal Bleeding
____Abnormal Discharge
____Fibroid Tumors
____Yeast Infections
____Irregular Periods
____Fertility Issue

Additional History

Have you even taken any of the following?

Supplement/Medication	Purpose	Last Taken
Oral Contraceptives		
Cortisone (shots)		
Tetracycline		
Thyroid Hormones		
Other Antibiotics		

List your current supplements/medications and their purpose:

Supplement/Medication	Purpose

Event Timeline

In chronological order, please list any significant events, traumas or stressors (physical or emotional).

Use an additional sheet if necessary.

Approximate Date	Event/Trauma/Stressor

Allergic Reactions

Please list the sensitivity reaction you experience from each allergen.

Drug/ Medication	Reaction

Inhalant	Reaction

Food/ Beverage	Reaction

Tree/ Plant/ Weed/ Etc.	Reaction

Nutritional Supplement	Reaction

Current Lifestyle

How many servings do you get per day, week or month? ***Write the number, and circle D (day), W (week), or M (month).***

___ (D / W / M) Fruits	___ (D / W / M) Vegetables	___ (D / W / M) Pasteurized Dairy
___ (D / W / M) Red Meat	___ (D / W / M) Poultry/Eggs	___ (D / W / M) Whole Grains
___ (D / W / M) Fish	___ (D / W / M) Nuts/Seeds	___ (D / W / M) White Flour Foods
___ (D / W / M) Soy Foods	___ (D / W / M) Cups of Water	___ (D / W / M) Caffeinated Drinks
___ (D / W / M) Juice	___ (D / W / M) Raw Foods	___ (D / W / M) Prepackaged Foods
___ (D / W / M) Sodas	___ (D / W / M) Sugary Snacks	___ (D / W / M) Restaurant Meals
___ (D / W / M) Alcohol	___ (D / W / M) Tobacco Products	___ (D / W / M) Recreational Drugs

How often do you exercise, for how long and what do you do?

Exercise/Activity/ Hobby	How often/ For how long

List and rate your issues/concerns on a scale of 0-10 (0 = no issue, 10 = worst imaginable)

Health or Personal Issues/Concerns:	**Rating**
1.	
2.	
3.	
4.	
5.	

List up to 5 specific health/life goals that we can help with:

1. _____
2. _____
3. _____
4. _____
5. _____

Approaches I am willing to consider and/or learn more about as a part of my healing plan:

- ☐ Colon Hydrotherapy
- ☐ Infrared Sauna
- ☐ Ionic Foot Bath
- ☐ Hyperbaric Oxygen
- ☐ Detox Baths
- ☐ Swedish or Deep Tissue Massage
- ☐ Lymphatic Drainage Massage
- ☐ Reflexology
- ☐ Energy Healing (Reiki, Angelic, etc)
- ☐ Acupuncture
- ☐ Diet/Nutrition
- ☐ Fasting (Juice, Smoothie, Intermittent, etc)
- ☐ Supplements (Vitamins, Minerals, Herbs)
- ☐ Homeopathy