Name:_____

Date of Birth:_____

Phone Number:_____

Email:_____

Country/State:_____

Height:_____

Weight:_____

Please list your top health concerns/ symptoms:

_____

_____

_____

_____

_____

Please tell me about your lifestyle (do you work, are you a stay at home parent, etc)?

_____

_____

_____

Do you feel heard & supported in your home/ family life?

_____

_____

Do you feel heard & supported at work?

_____

_____

What is your activity level like (how often do you work out, are you sedentary, etc)?

_____

_____

_____

_____

Please list anything you have officially been diagnosed with:

_____

_____

_____

Please list any surgeries you've had, anything you've had surgically removed, or any implants you've had (breast implants, titanium implants, mesh, etc):

_____

_____

_____

Have you had any recent testing and/or bloodwork done and if so, what did it reveal? Or, do you have a history of certain things showing on your bloodwork (like anemia, etc?

_____

_____

_____

Do you have any history of drug, alcohol, or nicotine dependency?

_____

_____

Do you regularly use, or consume alcohol, marijuana, CBD, vape pens, etc?

_____

_____

Tell me about your vaccination history (covid vaccines, flu shots, etc):

Tell me about your hormone history (low testosterone, other hormonal imbalances, PMS, PMDD, PCOS, heavy or irregular periods, menopause, etc):

Tell me about your birthing history (c-sections, vaginal births, etc):

Tell me about the condition of your hair, skin, & nails (hair-loss, brittle hair, dry skin, itchy skin, rashes, psoriasis, eczema, nail breakage, nail ridges, nails fungus, etc):

Tell me about your ears, nose, throat, & respiratory system (chronic ear infections, ear ringing, sinus infections, asthma, etc):

Do you have any joint or muscle pain?

Tell to me about your dental history (root canals, silver fillings, history of cavities, wisdom teeth removed, other teeth pulled out, braces, permanent retainer, implants, etc):

How many times per day do you have a bowel movement? Is it easy for you to go, or do you have diarrhea/constipation, etc?

Are you easily able to work up a sweat and/or do you deal with night sweats, or excessive sweating?

How is your sleep (do you struggle to fall asleep, struggle to stay asleep all night, do you snore, do you wake up to pee at night, etc)?

How are your energy levels during the day (do you feel fatigued, do you take naps, etc)?

Did you have any health issues as a child/ teen, or were you on a lot of antibiotics as a child/teen?

Do you have a history of being bitten by ticks, mosquitoes, spiders, fleas, etc, or was there a time in your life that you were covered in a lot of insect bites?

Have you ever lived, or worked in a place that had visible leaks in the celling, under the sink, smelled musty/moldy, or where you could actually see mold/mildew growing anywhere (like the window sills, or bathroom tile? Think back to your childhood home, as well…did you have a leaky, or musty smelling basement, or attic?

Do you keep your wifi router on 24 hours a day?

Do you sleep with your cellphone next to you?

Do you live next to cellphone towers, or large power lines?

Do you have a smart meter?

Do you have a microwave that you use regularly?

Do you often keep your cellphone tucked in your pocket?

How many hours per day would you estimate you are on your cellphone, laptop, etc?

Before bed, do you dim the lights, shut down electronics, wear blue blocking glasses, avoid looking at your smart devices, etc?

Do you use toothpaste that contains fluoride?

What kind of beauty and cleaning products do you use around the house (laundry soap, dish soap, hand soap, cleaning sprays, body wash, shampoo, conditioner, etc)?

Do you wear cologne or perfume?

What kind of make-up, skin-care, deodorant, or personal care products do you use?

Have you ever used over the counter antacids, or prescription antacids and if so, how long did you use them, or are you currently still using them?

Do you have an IUD, or use birth control; or have you used either in the past?

List any prescription/OTC medications you are using:

List any supplements you regularly take:

What kind of water do you drink (tap water, bottled water, reverse osmosis, distilled, alkaline, etc)?

Do you use a filter on your drinking water, shower, or bath water and if so, what kind?

Do you put trace mineral drops, or electrolytes into your water and if so, what brand do you use?

Do you drink coffee, tea, or energy drinks regularly and if so how much per day?

Do you drink your coffee, or other caffeinated drinks, on an empty stomach, before you've had a meal?

Including water, coffee, juice, etc, about how many ounces of liquid do you drink per day?

Do you feel hungry in the morning?

Do you skip breakfast regularly, because you're not feeling hungry, or are you practicing intermittent fasting?

How long after waking up do you eat your first meal?

Is there a certain diet you follow (vegan, vegetarian, carnivore, keto, paleo, etc)?

Do you avoid certain foods, because of allergies, or sensitivities and if so, what are those foods?

What do you typically eat for meals and snacks?

Are there any foods you crave?

_____

If there **<u>are</u>** foods you crave, do you crave those foods at certain times of day, during certain times of the year, or when you're feeling a certain way, emotionally?

_____

_____

When you feel hungry, or have a food craving, does it come on suddenly and feel like it has to be satiated instantly?

_____

_____

When you give in to your food cravings, do you feel guilty, or ashamed?

_____

The following questions are related to trauma and abuse. Studies show that those who have gone through trauma and/or abuse have a higher likelihood of developing health issues. These questions are not meant to be intrusive. They are meant to give me a better understanding of what you have gone through, so I can support you in the best way possible…..Being a fellow trauma survivor myself, I know these questions can be difficult to answer. If you feel uncomfortable answering them and wish to leave them blank, I completely respect your decision.

While growing up, did a parent, or other adult in the household often swear at you, insult you, humiliate you, or act in a way that made you afraid you might be physically hurt?

_____

Did a parent, or other adult in the household often push, grab, slap, throw something at you, or ever hit you so hard you had marks, or were injured?

_____

Did an adult, or person at least 5 years older than you ever touch you, fondle you, touch your body in a sexual way, or, attempt to have oral, anal, or vaginal intercourse with you?

_____

Did you often feel that no one in your family loved you, thought you were important, or special?

_____

Did your family look out for each other, feel close to each other, or support each other?

_____

Did you often feel that you didn't have enough to eat, had to wear dirty clothes, had no one to protect you?

_____

Were your parents too drunk, or high, to take care of you, or take you to the doctor, if needed?

_____

Were you parents ever separated, or divorced?

_____

Were any of your parents, or other adult caregivers often pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, hit with something hard, or threatened with a gun, or a knife?

_____

Did you live with anyone who had a problem with alcohol, or drugs?

_____

Was a household member, depressed, mentally ill, or ever attempt suicide?

_____

Did a household member go to prison, or jail?

_____