UR HEALING CONNECTION DBA

Wellness on the Mountain ~ Natural Health & Wellness is Our Goal for You!

NAME	EMAIL
ADDRESS	
	HOW OFTEN DO YOU CHECK:
	IS THIS A GOOD METHOD OF COMMUNICATION
TELEPHONE	
EMERGENCY CONTACT:	TODAY'S DATE

CURRENT SYMPTOMS /CONCERNS

CHALLENGES YOU FOUND WITH YOUR PLAN FROM OUR LAST VISIT

WOMEN'S HEALTH

DATE OF LAST MENSTRATION:

ANY DIFFFICULTIES?

HOW MANY DAYS OF CYCLE

ARE YOU EXPERIENCING ANY OF THESESYMPTOMS BON A REGULAR BASIS?

HOT FLASHES INSOMNIA FATIGUE CRAVINGS LOW LIBIDO VAGINAL DRYNESS

WEIGHT GAIN ANXIETY, IRRITABILITY, DEPRESSION, MOODY

MEN'S HEALTH

ANY ISSUES?

FREQUENT URINATION/ URGENCY TO URINATE/ BLADDER PAIN/ PAIN WITH URINATION/ OTHER

EXPLAIN

HEALTH GOALS FOR TODAY'S MEETING:	HEALTH GOALS LONG TERM:

WHAT HEALTH CHALLENGES HAVE YOU BEEN EXPERIENCING?

WHAT PERCENTAGE OF YOUR DAY IS STRESSFUL?

WHAT DO YOU DO FOR YOURSELF, WHEN STRESSED?

ARE THESE TECHNIQUES WORKING?

DO OTHER SAY YOU ARE ALWAYS STRESSED?

*SEE OTHER SIDE FOR MORE QUESTIONS. THANK YOU

FOOD INFORMATION SHARE WHAT YOUR FOOD CHOICES ARE NOW:

BREAKFAST	LUNCH	DINNER	SNACKS	LIQUIDS

WHAT MEALS ARE GIVING YOU THE MOST CHALLENGE?				

WHAT ARE YOUR CURRENT CRAVINGS? WHEN DO YOU CRAVE THEM?

HOW DO YOU HANDLE THE CRAVINGS?

CURRENT WEIGHT_____ IDEAL WEIGHT _____

DIGESTION

BOWEL MOVEMENTS **(*HOW MANY A DAY)** 1 /2 /3 / OTHER-EXPLAIN:

WHAT IS THE CONSISTANCY LIKE:

HOW OFTEN ARE YOU FEELING ANY OF FOLLOWING AFTER A MEAL: BLOATING / GAS / HEARTBURN / OT

ENERGY AFTER MEALS: HOW MUCH WATER DO YOU DRINK IN THE DAY:

WHAT ELSE ARE YOU DRINKING?

BODY TEMPERATURE MOST OFTEN:

CURRENT SUPPLEMENTS/HERBS/OILS/ETC	ORTHODOX MEDICATION:
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8

ENERGY LEVEL WHAT IS YOU ENERGY LEVEL AT THESE TIMES OF DAY?

UPON RISE:

MID DAY:

EVENING:

WHEN HEAD HITS THE PILLOW:

SLEEP

HOW MANY HOURS A NIGHT DO YOU SLEEP?

HOW MANY TIMES DO YOU WAKE ?

HOW LONG ARE YOU AWAKE?

HAVE YOU EXPERIENCED ANY OF THESE ITEMS ON A REGULAR BASIS?**CIRCLE THE ONES THAT APPLY TO YOU:*

NECK & BACK TENSION NERVOUS SYSTEM DISORDERS MUSCULAR PAIN PULSATING HEADACHES

SPASMS DIZZINESS CRAMPS INSOMNIA KIDNEY ISSUES MENSTRUAL ISSUES NUMBNESS

EMOTIONAL PROBLEMS LIKE DEPRESSION, ANGER, MOODINESS, *OTHER:*

CHANGE FOR THE BETTER

WHAT IS YOUR LEVEL OF COMMITMENT TO YOUR HEALTH?

ARE YOU A 100% COMMITTED?

WHAT ARE YOU WILLING TO DO, TO FEEL BETTER?

CIRCLE THE AREAS OF YOUR LIFE YOU WANT TO EXPAND OR IMPROVE:

*CREATIVITY	*PHYSICAL ACTIVITY	*JOY
*FINANCES	*HOME COOKING	*SPIRITUALITY
*CAREER	*HOME ENVIRONMENT	*SOCIAL LIFE
*EDUCATION	*RELATIONSHIPS	*HEALTH

OTHER:

PLEASE SHARE ANY OTHER OBSERVATIONS, CONCERNS OR MATTERS YOU WANT TO DISCUSS OR FOCUS:

PLEASE SIGN AND CONFIRM THAT ALL INFORMATION IN TRUE & COMPLETE. ADDITIONALLY, BY SIGNING THIS DOCUMENTYOU ACKNOWLEDGE THAT ALL INFORMATION SHARED TODAY WITH YOU IS FOR THE PURPOSE OF EDUCATION.YOUR VISIT TODAY IS NOT TO DIAGNOSE YOU.

SIGNATURE DATE

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