Alternative Lifestyle and Nutritional Therapy
'Your Health Is Your Greatest Wealth'
Marcilee Sterling-Green B.Sc., R.H.N.
chooseyourhealth@alinth.com web: www.alinth.com

Welcome to our Clinic

Please fill out the following questionnaire. The following information is use for your personal health consultation and will be used appropriately and kept confidential. All information used in your assessment will help to determine the appropriate recommendations necessary to improve your health.

Service location: _____ Date: _____

1st Visit Consultation: _____ Follow-up Visit: _____ Fee: _____

Have you been referred to us? Please give us their name so we can thank them. _____

Name: Mr. _Mrs. _Ms. _Miss. _____

Married _____ Divorced _____ Separated _____ Single _____

Home Address: _____

Shipping Address: _____

City: _____ State / Province: _____ Zip/ Postal Code: _____

Day Phone # (_____) _____ Evening Phone #: (_____) _____ Email: _____@_____

Primary Healthcare Physician _____ Address: _____

Date of last Visit: _____ Tel: _____

Emergency Contact: _____ Relationship _____

Tel. (_____) _____ Address:

_____

What is your occupation? _____ Do you enjoy your work? _____

Sex: M F DOB: _____ Age: _____ Weight: _____ Height: _____ Blood Type: _____

Vital Signs: Blood Pressure: _____/_____ Temp: _____ Pulse: _____ Resp: _____

Urinalysis: pH: _____ Glucose: _____ Proteins: _____ Blood: _____ Saliva pH: _____

Hours of Sleep Nightly _____

Your Cholesterol #'s: HDL: _____ LDL: _____ VLDL: _____ Triglycerides: _____ C-RP: _____

Cultural Heritage: (e.g. English, French, Italian, German, Native American, African American): _____

(For Women) Are you pregnant? Y N Are you still menstruating? Y N

Last period: _____ Are your periods: Heavy Regular Light Spotty Painful Irregular

Do you have vaginal dryness? Y N

Are you on Birth Control? Pill Shot Implant Patch Other: _____

Have you had any miscarriages? Y N Hysterectomy? Y N HRT Therapies Y N

(For Men) Your last prostate exam? _____ Have you had prostate surgery? Y N

Are you sexually active? Y N Do you have living children? Y N

Thyroid test Y N Have you had any surgery? Y N

If yes, please tell us what for: _____

Are you currently under a physician's care? Y N What for? _____

Are you currently on any medications prescribed by a health care provider? Y N Please list them below:

_____

Are you currently taking any nutritional supplements? Y N

If yes, please list the name brands, products, dosage and duration.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you a vegetarian? Y N Do you have religious dietary needs? Y N

How many times in the last two years have you been on antibiotics? _____ When? _____

How frequent are your bowel movements? One a day ____ Twice Daily _____ More? ____ Once a week _____

Describe your stool consistency?

Soft and easy Easy floater Hard and sinks Loose sometimes watery

Dark in Color Light in color Diarrhea Chronic Constipation

How frequently do you urinate? _____

Color of Urine: Dark Yellow Brown Orange Yellow Light Yellow Clear

Does your urine have a strong odor? Y N

Please list the foods you eat the most frequently.

_____

_____

Are there any foods you crave? _____

Foods you cannot eat for any reason? _____

Describe a typical breakfast, lunch and dinner:

Breakfast: _____

Lunch: _____

Dinner: _____

Do you ever skip meals? Y N Do you eat between meal snacks? Y N

List Snacks: _____

Do you use: Margarine Butter Olive Oil Corn Oil Coconut Oil NutraSweet Other: _____

Do you like spicy foods or condiments? Y N Do you use dairy? Y N

Do you eat nuts? Y N Raw Roasted What is your favorite nut? _____

Do you eat? White bread Whole Grain Bread Sprouted Grain Bread Whole Wheat Bread

Pasta White Rice Brown Rice Russet Potatoes Red Potatoes

How many times a week do you eat out or eat prepared packaged or canned food? _____

Do you eat fish? Y N What types: _____

What is your primary meat or vegetable protein source? _____

Do you eat vegetables: fresh frozen canned How many times a week? _____

Do you eat fruit: fresh canned dried frozen How many times a week? _____

Do you drink? Alcohol Coffee Green Tea Red Tea Herbal Tea Regular Tea Soda Pop

Diet Pop Energy Drink How many cups of coffee a day? _____ How many pops a day? _____

Water in ounces Daily _____ Filtered Water Y N

What level of stress do you often experience: Minimal____ Average_____ Considerable____ Unbearable____

Do you get regular exercise? 1-7 days a week: _____ How many hours or minutes do you generally exercise at a time? _____ What type of exercise do you do? _____

Do you attend a Church, Synagogue, Mosque, Temple, Drumming, or Group on a regular basis? Y N

What do you do for fun? _____ What is your favorite color? _____

What do you do to pamper or treat yourself? (e.g. hunting, camping, fishing, skiing, spa, massage, new cloths, shopping, reading, manicure, sunbathing? _____

Please tell us what your goal is by requesting a consultation. _____

What is the main reason for today's visit? _____

Family History

	Living Age	Health Problems	Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sibling -			
Sibling -			
Sibling -			

PLEASE CHECK OR CIRCLE ALL BOXES AND OR ANSWERS THAT APPLY TO YOU AND ARE DIAGNOSED:

- o Flatulence / GAS
- o Rheumatoid / Osteoarthritis
- o Sports injuries
- o Allergies / Seasonal, Food, Environment
- o Hair – Dry / Brittle / Losing / Dandruff / "Straw like" or Unmanageable hair
- o Alzheimer's / Parkinson's Disease
- o Headaches / Cluster, Migraine, Sinus
- o Stress / Anxiety / PTSD
- o Hearing Loss / Ringing / Infections / Wax
- o Heartburn / Acid reflux
- o Thyroid Problems / Hypo / Hyper
- o Hashimoto's
- o Hemorrhoids
- o Asthma
- o Herpes 1 -2
- o Urinary Tract Problems / Cystitis
- o Varicose Veins / Spider Veins
- o HIV/AIDS
- o Back / Neck Pain / Sciatica / Herniated / Bulged / Degeneration / Ruptured disk
- o Blood Clots /Stroke / Hypertension
- o Bone Spurs
- o Fluid Retention
- o Cancer / Cancer Treatments
- o Candida
- o Insomnia
- o Snoring /Sleep Apnea
- o Weakened Immune System, Frequent Colds or Flu
- o OPD
- o Cardiovascular Disease
- o Smoking Dependency
- o Carpal Tunnel Syndrome
- o Irritability / Depression / SAD
- o Cholesterol (High) / High Triglycerides
- o Skin Problems / Eczema, Rosacea, Acne, Liver spots, Dry/Oily
- o Cataracts / Floaters / Macular Degeneration
- o Kidney Health
- o Sinus Problems
- o Chronic Fatigue Syndrome
- o Low Libido
- o Lupus
- o Shingles
- o Prostate Problems / PID
- o Constipation
- o Lyme Disease
- o Bitten by a Tick
- o Osteoporosis
- o Osteomyelitis
- o Cravings
- o Fatigue
- o Adrenal Fatigue / Addison's Disease
- o Menopause /Hot Flashes
- o Fibromyalgia
- o Menstrual Cramps / PMS
- o Frequent Urination
- o Enlarged Prostate
- o Cystic Fibrosis
- o Dental Problems
- o Periodontal Disease
- o Multiple Sclerosis
- o Epilepsy
- o Diabetes 1 or 2
- o Hypoglycemia
- o Muscle Stiffness / Soreness
- o Hepatitis A B C
- o Rare Blood Diseases
- o Environmental Poisoning
- o Leg twitches or Cramps
- o Incontinence
- o Food Allergies / Food Sensitivity
- o Polycystic Ovarian Disorder (POD)
- o Digestive Problems / IBS / Crohn's / Gastric Bypass / Celiac disease / Colitis / Ulcers
- o Help Losing Weight / or Gaining
- o Cholecystectomy (Gall bladder)
- o Tonsillectomy / Adenoidectomy
- o Appendectomy
- o Splenectomy
- o Eating Disorder
- o Anemia
- o Blood Transfusions
- o Tattoos
- o STDs
- o Use Recreational Drugs / Medical Marijuana
- o IV Drug use
- o Irregular Heart Rhythm
- o ADD / ADHD / Autism
- o Finger nails: Chip easily, dry, brittle, peel, week, slow growing
- o Endometriosis
- o Fibrocystic Breasts
- o High Risk Sexual Activity
- o Excessive Thirst
- o Syndrome X or Metabolic Syndrome
- o Hard Bumps on Arms, Thighs or Elbows
- o Wilson's Syndrome
- o Myocardiopathy
- o Abdominal Fat
- o Cold Body Temp.
- o Thinning Skin
- o Decreased Muscle Mass
- o Mood Swings
- o Decreased Urine Flow

Signature: _____ Date: _____/_____/_____ (MM/DD/YY)

Thank you for taking the time to fill out the form. All information is confidential and will not be released to any authorities without your consent.