Essence of Healing LLC - Rosetta Kawauchi- Naturopath

www.KawauchiHolistic.com

TRINITY

Client Information Sheet

Name _____ **Age** _____

Address _____

Telephone (best) _____ **Email** _____

Reason for visit (prioritized):

1. _____
2. _____
3. _____

Nutritional data:

How many ounces of water/day? _____ What kind? _____

What other beverages and how much? _____

Do you use artificial sweeteners? _____ If so, which ones? _____

How often and in what? _____

Do you eat breakfast? _____ If so, what? _____

How much of the following do you consume? (example: 1D = 1/day, 2W = 2/week, 3M = 3/month)

Fresh fruit _____ Raw vegetables _____ Fermented foods _____

Fast foods _____ Meat _____ Eggs _____ Dairy _____

What do you crave? _____

What foods do you dislike the most? _____

Why? _____

_____

Timing:

What is the first thing you do when you get up in the morning? _____

_____

What time do you eat your first meal? _____ Last meal? _____

Which meal is your largest of the day? _____

Describe a typical largest meal. _____

_____

Movement:

Do you exercise/move/participate in fun sweaty activity? If so, what and how often?

_____

_____

Do you look forward to it? _____

How do you feel when you are finished? _____

Sleep:

What time do you go to bed? _____ How long do you sleep? _____
Do you wake often? _____
If so, why and at what time(s)? _____
Do you feel rested when you wake up for the day? _____
Do you have pain when you first get up? _____ If so, where? _____
_____
Does it go away upon moving? _____

Eliminations:

Do you have daily bowel eliminations? _____ If yes, how many per day? _____
If no, please describe your elimination pattern. _____
_____
Please indicate the most descriptive number(s) of your elimination(s) using the Bristol Stool chart provided. BSC # _____ Color _____

Females:

Are you post-menopausal? _____ If yes, at what age did you enter menopause? _____
What were the characteristics of your menopausal experience? _____
_____
Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? _____
Are you now, or in the near future, planning to become pregnant? _____
Is your menstrual cycle regular? _____ Longer than 28 days? _____ Shorter? _____
Is your flow longer or shorter than 5 days? _____
Do you have cramps or clotting? _____ Would you describe the color of your menses as bright red, dark purple, or brown? _____
Do you experience PMS, cyclical headaches, or cravings? _____

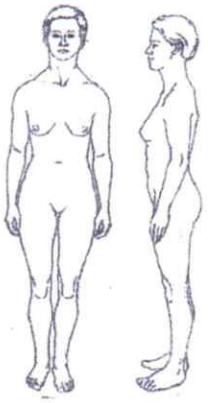
Supplements/medications:

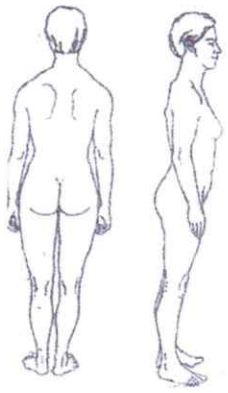
Do you take any supplements? _____ If so, what, how often and why? _____
_____
_____
Do you take any OTC medications routinely (such pain reliever or allergy medicine)? If so, what and how often? _____
Do you take prescription medications (prescribed by a licensed medical professional?) If so, what and how often? _____
_____

Medical history:

Have you had any surgeries? If so, what and when? _____
_____
Have you received any diagnoses from licensed medical professionals? If so, what and when? _____
_____

Mark on figures any areas of pain, tenderness, stiffness, swelling, discomfort or concern





Naturopathic history:

Have you ever been in consultation with a naturopath? If so, why? How long ago? _____

_____

_____

What was suggested? _____

Did you experience a good outcome? _____

What did you like about it? _____

What wasn't as successful for you? _____

Do you have regular adjustments with a chiropractor? _____

Do you have regular body work/massages? _____

Please check all with which you are familiar:

- ☐ Homeopathy
- ☐ Bach Flowers/flower remedies
- ☐ Probiotics
- ☐ Aromatherapy
- ☐ Muscle response testing
- ☐ Herbals
- ☐ Sports nutrition
- ☐ Enzymes

I understand that I am here to learn about wellness and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and that this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on holistic health matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature _____ Date _____

Mark current issues with a "C" and past issues with a "P".
Include the date(s) of occurrence and diagnosing practitioner.

Integumentary
_____ Rashes
_____ Eczema
_____ Psoriasis
_____ Hives
_____ Acne
_____ Itching
_____ Night sweats
_____ Dryness
_____ Change in moles
_____ Change in color/texture
_____ Hair loss
_____ Skin cancer
_____ Warts

Eyes
_____ Near-sighted
_____ Far-sighted
_____ Night/color blindness
_____ Eye pain
_____ Glasses/contacts
_____ Double vision
_____ Blind spot
_____ Cataracts
_____ Glaucoma
_____ Blurry vision
_____ Dry eyes
_____ Itchy eyes
_____ Tearing
_____ Red eyes
_____ Discharge

Mouth/Throat
_____ Frequent sore throat
_____ Sore tongue/mouth
_____ Gum problems
_____ Grinding of teeth
_____ Hoarseness
_____ Dental fillings
_____ Loss of taste
_____ Trouble swallowing
_____ Cold sores

Head
_____ Headaches
_____ Migraines
_____ Dizziness
_____ Trauma to head
_____ Dandruff

Ears
_____ Ringing
_____ Impaired hearing
_____ Earache/infections
_____ Dizziness
_____ Discharge
_____ Wax build up
_____ Itching
_____ Tubes

Upper Respiratory
_____ Frequent colds
_____ Wheezing
_____ Tonsillitis
_____ Swollen neck glands
_____ Sinus problems/infections
_____ Nasal discharge
_____ Post nasal drip
_____ Seasonal allergies
_____ Nose bleeds
_____ Coughing
_____ Sputum
_____ Hoarseness
_____ Wheezing
_____ Asthma
_____ Spitting up blood
_____ Shortness of breath
_____ Pain on breathing
_____ Difficulty breathing
_____ Bronchitis
_____ Pneumonia
_____ Tuberculosis

Gastrointestinal
_____ Indigestion
_____ Decrease in appetite
_____ Increase in appetite
_____ Increase in thirst
_____ Food Allergies
_____ Heart burn
_____ Nausea
_____ Vomiting
_____ Excessive belching
_____ Excessive flatulence
_____ Bloating
_____ Jaundice
_____ Liver Disease
_____ Gallbladder issues
_____ Hernia
_____ Ulcer
_____ Irritable bowel syndrome
_____ Crohn's disease
_____ Colitis
_____ Loose stools
_____ Hard stools
_____ Mucus in stool
_____ Blood in stool
_____ Black tarry stool
_____ Yellow/pale stool
_____ Greenish stool
_____ Rectal bleeding
_____ Hemorrhoids
_____ Rectal fissures
_____ Diverticulitis
_____ Abdominal pain

Blood/Lymph
_____ Anemia
_____ Easy bruising
_____ Easy bleeding
_____ Past transfusion
_____ Lymph node swelling
_____ Blood disease
_____ Blood type: _____

Cardiovascular

_____ Rapid heartbeat
_____ Heart disease
_____ Angina
_____ High blood pressure
_____ High cholesterol
_____ Heart murmur
_____ Rheumatic fever
_____ Chest pain
_____ Palpitation/fluttering
_____ Swollen ankles
_____ Abnormal heart tests

Peripheral Vascular

_____ Extremity swelling
_____ Varicose veins
_____ Extremity numbness
_____ Deep leg pain
_____ Extremity coldness
_____ Extremity ulcers

Neurological

_____ Fainting
_____ Seizures/convulsions
_____ Tingling/numbness
_____ Involuntary movement
_____ Loss of balance
_____ Speech problems
_____ Loss of memory
_____ Paralysis

Endocrine

_____ Thyroid disorder
_____ Heat/cold intolerance
_____ Excess sweating
_____ Hypoglycemia
_____ Chronic fatigue
_____ Hormone therapy
_____ Diabetes
_____ Seasonal depression
_____ Shift work disorder

Breasts

_____ Lumps
_____ Pain or tenderness
_____ Nipple discharge
_____ Breast implants
_____ Regular self-exam

Musculoskeletal

_____ Joint pain
_____ Joint stiffness
_____ Joint swelling
_____ Osteoarthritis
_____ Rheumatoid arthritis
_____ Muscle cramps
_____ Backache
_____ Neck pain/stiffness
_____ Flat feet/pain
_____ Weakness
_____ Sprained joints
_____ Broken bones

Emotional

_____ Angry
_____ Anxiety
_____ Argumentative
_____ Bad temper
_____ Depression
_____ Fear
_____ Grief
_____ Insomnia
_____ Irritable
_____ Low patience
_____ Low self-image
_____ Mood swings
_____ Nervousness
_____ Panic attacks
_____ Pessimism
_____ Phobias
_____ Suicidal thoughts
_____ Worrier

Urinary

_____ Frequent infections
_____ Pain on urination
_____ Burning on urination
_____ Increased urination
_____ Urination at night
_____ Increased urgency
_____ Incontinence/dribbling
_____ Hesitancy
_____ Strong urine odor
_____ Cloudy urine
_____ Blood in urine
_____ Bed wetting
_____ Kidney stones

Males

_____ Prostate problems
_____ Prostate surgery
_____ Hernia
_____ Testicular mass
_____ Testicular pain
_____ Discharge or sores
_____ Venereal disease
_____ Genital warts
_____ Sexually active
_____ Impotence
_____ Premature ejaculation
_____ Other sexual difficulties:

_____

_____

Women

_____ Hysterectomy
_____ Hormonal contraceptive
_____ Irregular cycles
_____ Bleeding between periods
_____ Painful menses/cramps
_____ Excessive flow
_____ Fibroids
_____ Ovarian cysts
_____ Cervical dysplasia
_____ Cervical/uterine cancer
_____ Vaginal discharge
_____ Vaginal itching
_____ Vaginal dryness
_____ Hot flashes
_____ Night sweats
_____ Difficulty conceiving
_____ Miscarriage(s) _____
_____ Birth(s) _____
_____ Regular PAP smears
_____ Painful intercourse
_____ Venereal disease
_____ Genital warts
_____ Sexually active
_____ Other sexual difficulties:

_____

_____

_____ **Other Concerns:**

_____

_____

_____