trinity
school of natural health

Individual Health Information Sheet

Name_____ Day Phone _____

Address _____ Night Phone _____

City _____ Cell Phone _____

State/Zip _____ Email _____

Relief from what top 3 symptoms (see back page) _____

Life Goals_____

How much sweaty activity weekly? _____ What type of activity? _____

How many ounces of water do you drink daily? _____ What type? RO Tap Spring Distilled

Which meals daily eaten? Breakfast Lunch Supper How many eliminations per day? _____

How many digestive enzymes daily? _____ How many breathing exercises daily? _____

How much of the following do you consume? (example, 1D = once daily, 3M = 3 times monthly)

Soda pop _____ Coffee _____ Smoking _____ Alcoholic Bev _____

Fast food _____ Milk_____ White Flour _____ Sugar usage _____

Raw fruit_____ Meat _____ Raw Veggies _____ Whole Grains _____

What types of food do you crave? Salty Chocolate Sweets Breads Other _____

What are your favorite foods? _____

How much daily energy (1 = lowest energy level; 10 = highest energy level) do you have? _____

What surgeries have you had and when? Circle NONE if applicable. _____

_____

How many hours of TV do you watch? Daily_____ Weekly_____

How many hours of spiritual enrichment each week? (Bible, prayer, church, etc.)_____

How many hours a week do you spend with family/friends? _____

How many hours of sleep do you get each night? _____ How many hours do you need? _____

What kind of prescription medication do you take? Circle NONE if applicable. _____

_____

Would you like to receive our natural health newsletter? YES NO

Who referred you for your appointment today? _____

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and 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 purposes 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 nutritional 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 _____

Symptoms and Areas of Concern (check all that apply)

- [ ] Acne
- [ ] ADD/ADHD
- [ ] Adrenal Glands
- [ ] Allergies
- [ ] Alzheimer's Disease
- [ ] Anemia
- [ ] Anger
- [ ] Anxiety
- [ ] Appetite
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Bad Breath
- [ ] Bed Wetting
- [ ] Bell's Palsy
- [ ] Bites
- [ ] Bladder
- [ ] Blood Pressure - High
- [ ] Blood Pressure - Low
- [ ] Boils
- [ ] Bones
- [ ] Breathing
- [ ] Bronchitis
- [ ] Bruises
- [ ] Burns
- [ ] Cancer
- [ ] Candida
- [ ] Canker Sores
- [ ] Carpal Tunnel
- [ ] Cataracts
- [ ] Chest Congestion
- [ ] Chest Pain
- [ ] Cholesterol
- [ ] Circulation
- [ ] Cold - Common
- [ ] Cold - Temperature
- [ ] Colic
- [ ] Colon
- [ ] Constipation
- [ ] Cough
- [ ] Cravings
- [ ] Dandruff
- [ ] Depression
- [ ] Diabetes
- [ ] Diarrhea
- [ ] Digestion
- [ ] Dizzy Spells
- [ ] Ear Infection
- [ ] Ear Ringing
- [ ] Edema
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Eyesight
- [ ] Fatigue
- [ ] Fever
- [ ] Flu
- [ ] Gallstones
- [ ] Gangrene
- [ ] Gas
- [ ] Gout
- [ ] Gums
- [ ] Hair Issues
- [ ] Headache
- [ ] Heart Issues
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Herpes
- [ ] Hiatal Hernia
- [ ] Hives
- [ ] Hormones
- [ ] Hyperactive
- [ ] Hypertension
- [ ] Hyperthyroidism
- [ ] Hypoglycemia
- [ ] Impotence
- [ ] Incontinence
- [ ] Indigestion
- [ ] Insomnia
- [ ] Joint Pain
- [ ] Kidney Issues
- [ ] Kidney Stones
- [ ] Laryngitis
- [ ] Leprosy
- [ ] Leukemia
- [ ] Liver
- [ ] Lung Issues
- [ ] Lupus
- [ ] Lymph Glands
- [ ] Menopause
- [ ] Menstrual Cramps
- [ ] Migraines
- [ ] Mononucleosis
- [ ] Mucous
- [ ] Nails
- [ ] Nausea
- [ ] Nervousness
- [ ] Nose Bleeds
- [ ] Parasites
- [ ] Parkinson's Disease
- [ ] Perspiration
- [ ] PMS
- [ ] Pneumonia
- [ ] Polyps
- [ ] Pregnancy
- [ ] Prostate
- [ ] Psoriasis
- [ ] Rash
- [ ] Reproductive
- [ ] Respiratory
- [ ] Rheumatism
- [ ] Ring worm
- [ ] Seizures
- [ ] Shingles
- [ ] Sinus
- [ ] Skin Issues
- [ ] Snoring
- [ ] Sore Throat
- [ ] Stomach
- [ ] Stress
- [ ] Stroke
- [ ] Sty
- [ ] Teething
- [ ] Tennis Elbow
- [ ] Tonsillitis
- [ ] Tumors
- [ ] Ulcers
- [ ] Urinary Infections
- [ ] Varicose Veins
- [ ] Vertigo
- [ ] Weight - Overweight
- [ ] Weight - Underweight
- [ ] Yeast Infections
- [ ] OTHER: