Rose Bridgeo, N.C.
Sarnia Holistic Health Partners
2109 A London Line, Unit Q
Sarnia, Ontario
519-336-7944

HEALTH EVALUATION

Name _____ **Date** _____

Address _____ **Date of Birth** _____

City _____ **Province** _____ **Postal Code** _____

Phone Numbers: _____
(for appointment confirmations)

Weight _____ **Height** _____ **Natural Hair Colour** _____ **Eye Colour** _____

Email address: _____

Please check this box ☐ ***if you wish to receive an email with our monthly newsletter.***

What other programs or direction and guidance have you received to date or are presently receiving to assist with your health? (Medical or Natural Health Professional)

_____

_____

_____

List any Vitamin, Mineral supplements or herbal or homeopathic remedies you are taking presently and the dosage;

_____

_____

_____

List any surgery you may have had

_____

_____

_____

Check any of the following conditions you are experiencing, As well as any medications you are taking:

Blood pressure: High_____ Low _____ Medication_____ Heart Medication _____

Diabetes_____ Insulin_____ Hypoglycemia_____ Headaches _____

Chronic Fatigue_____ Fibromyalgia_____ Hormones_____ Laxatives_____

Oral Contraceptives_____ Radiation _____ Chemotherapy _____ Steroids_____

Thyroid: Overactive _____ Underactive _____ Ulcer _____ Water Retention _____

Antacids _____ Antibiotics_____ Antidepressants _____ Anti inflammatory_____

MEDICATIONS: _____

_____

OTHER CONDITIONS OR MEDICATION NOT MENTIONED please list: _____

_____

_____

WHICH OF THE FOLLOWING FOODS DO YOU CONSUME REGULARLY?

Dairy_____ Egg_____ milk_____ Cheese_____ Ice-cream _____Yogurt _____creams___

Breads_____white_____grain_____wholewheat_____other_____

Pasta_____ from white flour_____ from other flours_____

Fruits Raw_____ Fruits Cooked_____

Vegetables Raw_____ Vegetables Cooked_____

Legumes_____ Grains/raw_____ processed foods_____ Fish_____

Fats, deep fried foods_____ Oils_____ Butter_____

Condiments_____Sauces_____Gravies_____

Meats_____ Red_____ poultry_____ pork_____ lamb_____

Processed Meats: cold cuts ____bacon____ smoked meats ____ sausages ____hot dogs____

Soy/Soy Products_____Alcohol_____Coffee_____Tea_____Water/Day_____

Pop _____ Sweetened Juices ____Unsweetened Juices _____ Natural Juices _____

Wine _____ Beer _____ Spirits _____

Do you have LOWER intestinal gas after eating? Yes_____ No _____

Do you have UPPER gas such as burping and belching after eating? Yes_____ No.____

Heartburn Yes _____ No _____

Number of bowel movements per day, _____ colour _____ status: loose_____, hard_____, thin or

Pencil-like _____, or other significant details _____

<u>SLEEP PATTERN</u> well_____ restless _____ insomnia_____, or other valuable

comments_____

Do you get colds or flus often? Yes ____ No _____ Once or twice per year? Yes _____ No _____

Do you recover quickly from ailments? Yes _____ No _____

Would you say your energy level is: Good _____ Not bad _____ Poor_____

<u>COMMENTS ON GENERAL FEELING OF WELL BEING</u> good _____ great _____

Depressed ____ sleepy ____ moody ____ light headed ____ spacey _____ dizzy _____

What is your present level of physical activity?

_____

_____

Additional comments related to your health

A HOLISTIC NUTRITIONAL HEALTH PROGRAM WILL BE SPECIFICALLY DESIGNED FOR YOUR PERSONAL HEALTH NEEDS BASED ON THE INFORMATION YOU HAVE PROVIDED.

Rose A. Bridgeo / Certified Holistic Nutritionist