Healing With Dr. HERBert
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Client Information Sheet

Name **Age** 0

Address

City, State, Zip

Telephone (best) **Email**

Reason for visit:

Nutritional data:

How many ounces of water/day? 0 What kind?

What other beverages and how much?

Which meals do eat daily? ☐ Breakfast ☐ Lunch ☐ Dinner

If you have breakfast, what do you eat normally?

Do you use artificial sweeteners?

If so, which ones, how often and in what?

What do you crave? ☐ Salty ☐ Chocolate ☐ Sweets ☐ Breads Other

What are your favorite foods?

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.

How much of the following do you consume?

Smoking 0 **Per**

Coffee 0 **Per**

Soda pop 0 **Per**

Alcohol Beverages 0 **Per**

Sugar 0 **Per**

Fruit 0 **Per**

Vegetables 0 **Per**

Eggs 0 **Per**

Dairy 0 **Per**

Fermented food 0 **Per**

Fast food 0 **Per**

Chicken 0 **Per**

Fish 0 **Per**

Red Meat 0 **Per**

Pork 0 **Per**

Meat Alternatives 0 **Per**

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? 0

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? 0

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? 0

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?

Naturopathic history:
Have you ever been in consultation with a naturopath?

If so, why?

How long ago? 0 What was suggested?

Did you experience a good outcome?

What did you like about it?

What was not 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

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
- [ ] 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
- [ ] Overweight
- [ ] 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
- [ ] Stye
- [ ] Teething
- [ ] Tennis Elbow
- [ ] Tonsilitis
- [ ] Tumors
- [ ] Ulcers
- [ ] Underweight
- [ ] Urinary Infections
- [ ] Varicose Veins
- [ ] Vertigo
- [ ] Yeast Infections

Other

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements, herbs, exercises, and lifestyle alterations or maintenance as a guide to general good health. I fully understand that those who counsel me are NOT medical doctors, and I am not here for medical diagnostic purposes, or medical treatment procedures. I am free to apply the information, guidance, and products received from this practice and its personnel to my benefit or choose otherwise. 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, exercises, or lifestyle alterations intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies or medications for a disease of any type.

I attest that I have answered any and all questions to the best of my ability in all honesty for review and will not hold liable any and all parties associated with the practice listed on this form or its affiliates for outcomes resulting in contrast or adversity due to the omission or incorrect answers to said questions presented to me on this form. The answers to these questions presented to me and any information given to me by this practice and its personnel during my initial consultation, standard appointments, follow-up appointments, scheduled sessions, or approved meetings, be it in person or virtual, will remain under the doctor to client privilege relationship thus completely confidential between parties and will not be shared with any individual that is not duly authorized by the practice and its personnel and myself.

You have reviewed and agreed with the terms of the form. By checking the “I Accept And Sign” box and typing your name on the Signature line below, you are signing this agreement electronically. You agree that your typed signature is the legal equivalent of your physical signature on this form. By checking the “I Accept And Sign” box and typing your name on the Signature line you consent that you are authorized to act on behalf of yourself or the person to which you are legal guardian to the terms outlined on this form and you consent, on behalf of yourself or the person to which you are legal guardian, to be legally bound by the agreement and all its terms and conditions.

☐ I Accept And Sign

Signature Date