Name:_____

Date of Birth:_____

Phone Number:_____

Email:_____

Country/ State:_____

Height:_____

Weight:_____

Please list your top health concerns/ symptoms:

_____

_____

_____

_____

_____

Please tell me about your lifestyle (do you work, are you a stay at home parent, etc)?

_____

_____

_____

Do you feel heard & supported in your home/family life and/or at work?

_____

_____

What is your activity level like (how often do you work out, are you sedentary, etc)?

_____

_____

_____

_____

Please list anything you have officially been diagnosed with:

_____

_____

_____

Please list any surgeries you've had (gallbladder removed, breast implants, titanium implants, mesh, etc):

_____

_____

_____

Have you had any recent testing and/or bloodwork done and if so, what did it reveal? Or, do you have a history of certain things like anemia, etc?

_____

_____

_____

Do you have any history of drug, alcohol, or nicotine dependency?

_____

Do you regularly use, or consume alcohol, marijuana, CBD, vape pens, etc?

Tell me about your vaccination history (covid vaccines, flu shots, etc):

Tell me about your hormone history (low testosterone, other hormonal imbalances, PMS, PMDD, PCOS, heavy or irregular periods, menopause, etc):

If you are a female, tell me about your birthing history (c-sections, vaginal births, trauma around birth, etc):

Tell me about the condition of your hair, skin, & nails (hair-loss, brittle hair, dry skin, itchy skin, rashes, psoriasis, eczema, nail breakage, nail ridges, nails fungus, etc):

Do you have any joint or muscle pain?

Tell me about your ears, nose, throat, & respiratory system (chronic ear infections, ear ringing, sinus infections, asthma, etc):

Tell to me about your dental history (root canals, silver fillings, history of cavities, wisdom teeth removed, other teeth pulled out, braces, permanent retainer, implants, etc):

How many times per day do you have a bowel movement? Is it easy for you to go, or do you have diarrhea/constipation, etc?

Are you easily able to work up a sweat and/or do you deal with night sweats, or excessive sweating?

How is your sleep (do you struggle to fall asleep, struggle to stay asleep all night, do you snore, do you wake up to pee at night, etc)?

How are your energy levels during the day (do you feel fatigued, do you take naps, etc)?

Did you have any health issues as a child/teen, or were you on a lot of antibiotics as a child/teen?

Is there a family history of health issues, or certain diagnoses?

Do you have a history of being bitten by ticks, mosquitoes, spiders, fleas, etc, or was there a time in your life that you were covered in a lot of insect bites?

Have you ever lived, or worked in a place that had leaks in the celling, under the sink, smelled musty/moldy, or you could see mold/mildew growing anywhere (like the window sills, or bathroom tile? Think back to your childhood home, as well… did you have a leaky, or musty smelling basement, or attic?

Do you keep your wifi router on 24 hours a day?

Do you sleep with your cellphone next to you?

Do you live next to cellphone towers, or large power lines?

Do you have a smart meter?

Do you have a microwave that you use regularly?

Do you often keep your cellphone tucked in your pocket?

How many hours per day do you estimate you're on your smart devices?

Before bed, do you dim the lights, shut down electronics, wear blue blocking glasses, avoid looking at your smart devices, etc?

_____

Do you use toothpaste that contains fluoride?

_____

What brands of beauty and cleaning products do you use around the house (brand names of laundry soap, dish soap, hand soap, cleaning sprays, body wash, shampoo, conditioner, etc)?

_____

_____

_____

Do you wear cologne or perfume?

_____

What brands of make-up, skin-care, deodorant, or personal care products do you use?

_____

_____

Have you ever used over the counter antacids, or prescription antacids and if so, how long did you use them, or are you currently still using them?

_____

_____

Do you have an IUD, or use birth control; or have you used either in the past?

_____

List any prescription/OTC medications you are using:

_____

_____

_____

List any supplements you regularly take:

_____

_____

_____

What kind of water do you drink (tap water, bottled water, reverse osmosis, distilled, alkaline, etc)?

_____

Do you use a filter on your drinking water, shower, or bath water and if so, what brand?

_____

Do you put trace mineral drops, or electrolytes into your water and if so, what brand do you use?

_____

Do you drink coffee, tea, or energy drinks regularly and if so how much per day?

_____

Do you drink your coffee, or other caffeinated drinks, on an empty stomach, before you've had a meal?

Including water, coffee, juice, etc, about how many ounces of liquid do you drink per day?

Do you feel hungry in the morning?

Do you skip breakfast regularly, because you're not feeling hungry, or are you practicing intermittent fasting?

How long after waking up do you eat your first meal?

Is there a certain diet you follow (vegan, vegetarian, carnivore, keto, paleo, etc)?

Do you avoid certain foods, because of allergies, or sensitivities and if so, what are those foods?

What do you typically eat for meals and snacks?

Are there any foods you crave?

Do you, or a close family member have a history of dieting, eating disorders, or negative feelings about certain foods, etc?

While growing up, did you experience physical, verbal, or sexual abuse?

Were you parents ever separated, or divorced?

Did you live with anyone who had a problem with alcohol, drugs, or mental illness?