

- Enhealthment Consultation Notes -

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

Main health concern to talk about during this consultation. \_\_\_\_\_

\_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure (if known): \_\_\_\_\_

Pregnant? Due date \_\_\_\_\_  Breastfeeding? How old is child? \_\_\_\_\_

Are you presently receiving treatment from a doctor or hospital? If so, please give brief details.

\_\_\_\_\_

\_\_\_\_\_

Are you presently seeing other alternative healthcare practitioners? If so, please give brief details. \_\_\_\_\_

\_\_\_\_\_

List any medications you are taking and the reason for taking them: \_\_\_\_\_

\_\_\_\_\_

List any supplements you are taking (vitamins/herbs/homeopathic): \_\_\_\_\_

\_\_\_\_\_

Have you ever been diagnosed with a major illness? (disease and approximate date of diagnosis) \_\_\_\_\_

\_\_\_\_\_

List any known allergies or sensitivities and the reaction you experience. \_\_\_\_\_

\_\_\_\_\_

What is your Fitness Level: Sedentary Moderately Fit Very Fit Extremely Fit

Briefly describe your fitness routine. \_\_\_\_\_

\_\_\_\_\_

List any hobbies you participate in. \_\_\_\_\_

\_\_\_\_\_

Describe the amount of stress in your life and how it affects your health. \_\_\_\_\_

\_\_\_\_\_

How would you describe your eating habits?

Poor (*Mostly convenience/ fast food.*)

OK (*Occasional convenience/fast food.*)

Good (*I pay attention to what I eat, read food labels and try to follow proper nutrition.*)

Describe your typical breakfast. \_\_\_\_\_

\_\_\_\_\_

Describe your typical lunch. \_\_\_\_\_

\_\_\_\_\_

Describe your typical supper. \_\_\_\_\_

\_\_\_\_\_

Describe your typical dessert. \_\_\_\_\_

Describe your typical snacks, as well as when and how often you snack. \_\_\_\_\_

\_\_\_\_\_

How much water do you drink in a day? \_\_\_\_\_

Do you smoke? No Yes. How often: \_\_\_\_\_

Do you drink alcohol? No Yes. How often: \_\_\_\_\_

Do you use street drugs? No Yes. Type & how often: \_\_\_\_\_

Do you drink coffee or other caffeinated drinks? No Yes. How often: \_\_\_\_\_

Do you take sugar in your coffee/tea? No Yes. How much per cup: \_\_\_\_\_

