New Client Information Sheet

Tonya Holcomb
LOVE YOURSELF **FIERCELY**
TONYAHOLCOMB.COM

Please write or print clearly.

Today's Date: _____

Name:_____

Address:_____

Email address:_____ How often do you check email? _____

Telephone – Work: _____ Home: _____ Cell: _____

Age: _____Height: _____Date of Birth: _____Place of Birth:_____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what?_____

Relationship status: _____

Children (with ages):_____ Pets:_____

Occupation:_____ Hours of work per week: _____

List your main (Top 5) health concerns:

_____

_____

_____

_____

Other concerns and/or goals?

_____

_____

_____

_____

At what point in your life did you feel best?

_____

_____

_____

_____

Any serious illnesses/hospitalizations/surgery/injuries?

_____

_____

_____

_____

Please check whatever applies from below:

- ☐ No Energy
- ☐ Headaches
- ☐ Backaches
- ☐ Muscle Problems
- ☐ Bad Digestion
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Depression
- ☐ Complexion Concerns
- ☐ Low Appetite
- ☐ High Appetite
- ☐ Hiatus Hernia
- ☐ Sexual Dysfunction
- ☐ Pregnant
- ☐ Chronic Indigestion
- ☐ Allergies
- ☐ Gas / Bloating
- ☐ Asthma
- ☐ Female Concerns
- ☐ Constipation
- ☐ Diarrhea
- ☐ Cold Hands / Feet
- ☐ Swollen / Painful Joints
- ☐ Frequently Sick
- ☐ Heartburn
- ☐ Insomnia
- ☐ Cannot Relax
- ☐ Low / High Blood Sugar
- ☐ Male Concerns

Level of exercise? _____

How is/was the health of your mother? _____

How is/was the health of your father? _____

What is your ancestry (heritage)? _____ What blood type are you? _____

Do you sleep well?_____ How many hours? _____ Do you wake up at night (time)? _____

Why? _____

Any pain, stiffness or swelling? _____

Are your periods regular? _____ How many days is your flow?_____ How frequent? _____

Painful or symptomatic? Please explain: _____

Reached or approaching menopause? Please explain: _____

_____

Birth control history: _____

Do you experience yeast infections or urinary tract infections? Please explain: _____

_____

How many bowel movements do you have per day? Any problems? _____

Allergies or sensitivities? Please explain: _____

_____

_____

Do you take any supplements or medications? Please list:_____

_____

_____

_____

Any healers, helpers or therapies with which you are involved? Please list: _____

_____

_____

_____

What role does sports and exercise play in your life?

_____

_____

What foods did you eat often as a child? teenager? college?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____

What's your food like these days?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Liquids _____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

_____

_____

What percentage of your food is unprocessed and home cooked? _____ Do you cook? _____

Where do you get the rest of your meals from? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

_____

The most important thing I should change about my diet to improve my health is:

_____

_____

Have you experienced significant grief or emotional stress (recently or in the past)?

_____

_____

Anything else you want to share?

_____

_____

IMPORTANT: By signing below, I understand that the suggested nutritional program and dietary information is not intended as primary therapy for any disease or symptom. My intention is to find a good nutritional program that will assist me in changing my habits and establishing a new lifestyle in order to build good health naturally. I understand that dietary health program is not for the diagnosis, cure, mitigation, treatment or prevention of disease; this is an adjunctive schedule of nutrients solely provided to upgrade the quality of foods in my diet in order to supply good nutrition for supporting the physiological and biochemical process of the human body.

I understand that the natural health consultant I am visiting is not a medical doctor and does not treat or diagnose medical conditions; that this is not a replacement for medical counseling; that if I have a medical condition, I will seek a qualified medical professional.

I understand that it is my personal decision whether or not to follow the natural health suggestions offered.

_____ _____

Signature Date