



**essential balance**  
*Build Another Lifestyle... A New Changing Experience*

## Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ E-mail: \_\_\_\_\_

**How did you hear of our services?** \_\_\_\_\_

- 1- Please state your primary reason for attending our office.
  
- 2- Please list your health goals.
  - a)
  
  - b)
  
  - c)
  
- 3- Have you been diagnosed with a disease, virus, or medical condition? If so, which one(s) and when the diagnosis was made. (Example: Asthma, Cancer, Thyroid Disease, etc.)
  
- 4- Have you had any re-occurring infections or inflammations? (Example: Tonsillitis, bladder/ear infections, colitis, etc.)
  
- 5- Please list any prescription medications you are currently taking, and why/what condition.
  
- 6- Please list any supplements and **name brands** (vitamin, mineral, herbal) you are currently taking.

- 7- Do you have any allergies? (Environment, food, animals) Please specify.
  
- 8- Do you attend any other health care professionals? (Dr, RMT, Chiropractor, Homeopath etc.). Please specify.
  
- 9- Have you ever been hospitalized or had an operation? Please specify, including dates.

## Family History

10- Please indicate whether there is any history of the following conditions in your family. Indicate with an "x"

Condition	Mother	M GP	Father	F GP	Brother	Sister		Aunt	Uncle
Alcoholism									
Cancer									
Mental Illness									
GI disorder									
High BP									
Heart Disease									
Allergies									
Diabetes									
Psoriasis									
Auto-immune									
Osteoarthritis									
Rheumatoid Arthritis									
Asthma									
Eczema									
OTHER>>									

\* M GP = Mother Grand Parents F GP = Father Grandparents



## Lifestyle

11- Do you exercise on a daily basis? Does your program include cardio and weight training? Please specify.

12- Are you a smoker? If so, how many do you smoke a day? If no, are you exposed to a second hand smoke on a regular basis or are you an ex-smoker?

13- Do you drink coffee, tea, or pop on a daily basis? If so, please specify.

14- On average, how many alcoholic beverages do you consume in a week?

15- Do you feel "stressed" on a regular basis? If yes, please indicate sources of stress.

/10

## Informed Consent:

I hereby attest to the following: I clearly understand that my nutritionist is not a medical doctor and I am not here for medical diagnostic or treatment procedures. The services performed by my nutritionist are at all times restricted to consultation on the subject of nutritional I well-being and do not involve the diagnosing, prognosticating, treatment, or prescribing of remedies for the treatment of any disease, or any licensed or controlled act which may constitute the practice of medicine in this province. This agreement is being signed voluntarily and not under duress of any kind.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

---

**Does your health plan cover Nutritional Consultations from an RNCP?  
(Registered Nutritional Consultant Practitioner) \_\_\_\_\_**

*Thank You! We look forward to helping you successfully achieve your health goals!*