Consultation Information

1. Please fill out the client questionnaire and body system questionnaire and bring the completed forms to your appointment.

2. Bring all of your medications and supplements with you.

3. Take all prescribed medications but DO NOT take any vitamins or supplements the day of the assessment.

4. Please give 24 hours notice if you will not be able to make your appointment!

I look forward to seeing you!

Laura McClendon, PT, CNHP
903-283-0468

Client Consultation Questionnaire

I. Personal Information

LAST NAME _____ FIRST NAME _____ DATE _____

DATE OF BIRTH _____ AGE _____ SEX _____ PERSON WHO REFERRED _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE (DAY)____ _____ (NIGHT) _____

CELL/FAX _____ E-MAIL_____

HEIGHT _____WEIGHT _____ OCCUPATION _____BLOOD TYPE_____

II. Diet, Nutrition and General Health Practices

A. How many meals each day do you eat? _____ How many bowel movements each day do you have? _____

B. Food or medication you are allergic to._____

C. How much water do you drink each day? _____ cups. What kind of water do you drink?_____

D. How often do you exercise?_____ How long? _____ What do you do for exercise? _____

E. What is your energy level like?_____

F. Do you feel like you are under stress? _____ If so, explain. _____

H. What nutritional supplements are you currently taking? _____

I. How often do you consume the following (1 = daily, 2 = 3 x weekly, 3 = weekly, 4 = 1-2 x month, 5 = never)

Refined sugar	1 2 3 4 5	White flour	1 2 3 4 5	Table Salt	1 2 3 4 5	Red meat	1 2 3 4 5
Dairy Products	1 2 3 4 5	Pork	1 2 3 4 5	Vegetables	1 2 3 4 5	Green salads	1 2 3 4 5
Caffeine drinks	1 2 3 4 5	Fresh fruits	1 2 3 4 5	Fried foods	1 2 3 4 5	Shellfish	1 2 3 4 5

III. Medical Information

A. What conditions are you taking medication for? _____

B. ____ Do you have a diagnosis from the doctor? If so, what? _____

C. Are you using chemical birth control? _____ Are you pregnant?_____ If yes, how far along are you? _____

D. What are your current health concerns?_____

_____

Specific Symptoms

A. Have you been diagnosed by a licensed physician with any of the following? Check all that apply.

- ❑ AIDS
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Colitis
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Irritable Bowel Syndrome
- ❑ Low Thyroid
- ❑ Lupus
- ❑ Osteoporosis
- ❑ Multiple Sclerosis
- ❑ Ulcers

B. **Do you suffer from any of the following? Check all that apply.**

- ❑ Abdominal pain
- ❑ Absent-mindedness
- ❑ Acid Indigestion or heartburn
- ❑ Alcoholism
- ❑ Allergies, foods
- ❑ Allergies, respiratory
- ❑ Anemia
- ❑ Anger, excessive
- ❑ Anxiety, nervousness
- ❑ Back pain
- ❑ Bad breath or body odor
- ❑ Bladder infections
- ❑ Brittle fingernails
- ❑ Burning or painful urination
- ❑ Chest pain
- ❑ Cold hands and feet
- ❑ Cold sores
- ❑ Congested air passages
- ❑ Constipation or dry stools
- ❑ Coughing, chronic
- ❑ Cravings fats or fried foods
- ❑ Cravings for sugar
- ❑ Dark circles under eyes
- ❑ Depression
- ❑ Diarrhea
- ❑ Difficult urination
- ❑ Difficulty getting to sleep
- ❑ Dizziness or light-headedness
- ❑ Dry skin or eyes
- ❑ Eczema
- ❑ Erection difficulty
- ❑ Excess mucus production
- ❑ Excess weight
- ❑ Family history of heart disease
- ❑ Fatigue in the afternoons
- ❑ Fatigue, excessive
- ❑ Fatigue, in the morning
- ❑ Fear, excessive
- ❑ Food allergies
- ❑ Food sits heavy on stomach
- ❑ Frequent infections
- ❑ Frequent thirst
- ❑ Frequent urination
- ❑ General weakness or chronic illness
- ❑ Hay fever
- ❑ Headaches
- ❑ Heart palpitations
- ❑ Heavy Periods
- ❑ Hemorrhoids
- ❑ High blood pressures
- ❑ High cholesterol
- ❑ Hot flashes
- ❑ Hypoglycemia
- ❑ Impotence (males only)
- ❑ Incontinence
- ❑ Infertility
- ❑ Intestinal gas or bloating
- ❑ Irritability
- ❑ Itching skin
- ❑ Itchy nose or ears
- ❑ Jaundice
- ❑ Joint pain or gout
- ❑ Leg cramps or pain
- ❑ Loose stool or diarrhea
- ❑ Loss of or poor appetite
- ❑ Loss of sexual desire
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Migraine headaches
- ❑ Mood swing
- ❑ Muddled thinking, confusion or mental sluggishness
- ❑ Muscle tension
- ❑ Panic attacks
- ❑ PMS (females only)
- ❑ Poor appetite
- ❑ Prostrate problems
- ❑ Puffiness under eyes
- ❑ Rapid heart beat
- ❑ Rashes
- ❑ Restless dreams or nightmares
- ❑ Ringing in the ears
- ❑ Scant or excessive urination
- ❑ Sensation of lump in throat
- ❑ Sinusitis or sinus congestion
- ❑ Sinus headaches
- ❑ Skin problems(acne, rashes)
- ❑ Stiff or aching muscles
- ❑ Stomachache
- ❑ Swollen lymph glands
- ❑ Teeth grinding
- ❑ Underweight or unable to gain weight
- ❑ Urinating at night
- ❑ Varicose veins
- ❑ Waking up frequently
- ❑ Water retention or edema
- ❑ Weak legs, knees or ankles
- ❑ Wheezing or shortness of breath
- ❑ Wounds won't heal
- ❑ Yeast infection

To establish and clarify my purpose in coming to Laura McClendon for a consultation, I want to clearly state that my interest is in learning more about natural health and finding a good path to follow concerning my nutritional needs. I understand that it is my personal decision to follow a nutritional and supplement program or not to follow it. I thoroughly understand that this analysis does not replace any additional professional counseling with any health care professional. This analysis and nutritional recommendation is an adjunctive analysis which can be coordinated with other treatments and is not intended to be in any way a diagnosis or conflict with any other recommendations or treatments by other practitioners who are licensed by state and federal laws, and also the decision to follow or reject this program is left to my own discretion. In addition, I fully and completely understand that Laura McClendon does not treat nor does she make any recommendation for the treatment of disease in any form or in any manner whatsoever, and I wish to assure you that I am in no way asking for such treatment. If I have a medical condition, it is my responsibility to seek out a qualified medical professional or physician. I clearly understand that this analysis and consultation is not meant to take the place of any other forms of analysis, counseling or diagnosis by a physician or health care professional. I understand that Laura McClendon deals with assessments and suggestions that are from a naturopathic point of view and not a medical point of view. I understand that Laura McClendon is not a medical doctor and that she does not diagnose, treat or prescribe for medical conditions.

I am willing make lifestyle choices that support my optimal health. On a scale of 0 to 10, 0=not willing, 10=fully committed to make changes. Circle your answer. 0 1 2 3 4 5 6 7 8 9 10

Date _____ Signature or Parent/ Guardian_____

Body System's Questionnaire

Client Name _____ **Date**_____

Directions: If you have problems with any of the symptoms listed on the left hand side of the table, then circle all the numbers on the row to the right of that symptom. When you have finished reviewing the list of symptoms, total all the numbers you have circled in each column. There are spaces provided at the bottom of each page to total the columns on that page and a space on page two for the Grand Totals. The higher the number, the more likely it is that the body system associated with that column needs nutritional support.

Abdominal Pain or Discomfort	1	1	1								
Absent-mindedness or forgetfulness						2	2	1			
Acid indigestion or heartburn	2										
Anxiety, nervousness or tension	1						2	1			
Asthma	1	1		2							
Bad breath or body odor			1		1						
Brittle fingernails									2		1
Burning or painful urination					2						
Cold hands and feet						1		1			
Colitis or other bowel irritations		1	2							1	
Congested air passages			1	2						1	
Constipation or dry stools			2				1				
Cravings for fat or high fat diet		1				2					
Cravings for sugar	1							2			
Dark circles or puffiness under eyes		1			1			1			
Difficulty getting to sleep		1					2	1			
Dizziness or light headedness.						1		1			
Dry Skin								1	1		
Excess mucus production			1	2							
Family history of heart disease						2					
Fatigue in the afternoons								1			
Fatigue or low energy levels		1	1			1	1	1		2	
Food allergies	1	1								2	
Food sits heavy on stomach after eating	2										
Frequent backache					2				2		
Frequent cough				2						1	
Frequent infections				1						2	
Frequent urinary tract infections					2						
General weakness or chronic illness	2									2	1
Hayfever		1	1	2						2	
Heart problems						2					
High blood pressure					1	2	2				
High cholesterol		1				2					
Impotency (males only)											2
TOTALS FOR SIDE ONE											

Infertility											2
Intestinal gas or bloating	2	1	1								
Itchy nose and ears				1						1	
Joint pain, arthritis or gout					1				2		
Leg cramps or pains					1				2		
Less than 1 bowel elimination per day		1	2								
Loose stool or diarrhea		1	2								
Loss of appetite or poor appetite	2						1	1			
Loss of sexual desire											2
Menopause Problems (Females only)											3
Menstrual problems (females only)							1				3
Mental/emotional stress							2	2			1
Migraine headaches		2				1	2				
Muddled thinking, confusion or mental sluggishness			1				1	2			1
Osteoporosis					1				2		2
Pale complexion and/or anemia	1					1				1	
Prostate problems (males only)											3
Restless dreams or nightmares			1				1	1			1
Scant or excessive urination					2						
Sinus congestion			1	2						1	
Sinus headaches			1	2							
Skin problems (acne, rashes, etc.)		2			1				2	1	2
Stiff, aching or painful muscles		1	1		1				2	1	
Swollen lymph glands		1		2						2	
Ulcers	2										
Underweight or unable to gain weight	2							1			
Urinating at night					1		1	1			
Varicose Veins		1				2			1		
Waking up frequently at night							1	1			
Water retention or edema					2						
Weak legs, knees or ankles					1				2		1
Wheezing or shortness of breath				2							
Wounds won't heal in extremities						1			2		
TOTALS FOR SIDE TWO											
TOTALS FOR SIDE ONE											
Grand Totals											
Body Systems	Digestive	Hepatic	Intestinal	Respiratory	Urinary	Circulation	Nerves	Glandular	Structural	Immune	Reproductive

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