ROYALEMPOWENT
Barbara Reale
tailormade
anti aging nutrition
at a cellular level

een vrije zorgkeuze

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Please fill in the following information prior to your first appointment and give directly to your naturopath when you arrive to ensure complete confidentiality. If there is any information that you do not feel comfortable writing down or would rather discuss in person, just mark a star beside the question and it can be addressed during your appointment if you wish.

Date____Name_____e_mail_____ Adress_____
Phone#_____ Date of Birth _____ Gender__ Height_____ Weight_____
Health Insurance name & package name_____
When during the day is your energy and alertness best? _____
Worst?_____ How did you hear about me_____
Other health care providers you see_____
Date and kind of last medical physical exams: _____
Where these tests normal? (Y/N) Date of last blood tests Where these tests normal? (Y/N)
Occupation_____ Full or Part time_____ Hobbies_____
What is your main reason for seeing a naturopath?_____
List any other health concerns that are troubling you & the length of time they have been a problem _____
What are your goals regarding your naturopathic consultation/coaching?_____
_____

Long-term_____
Past medications and length of time taken: _____
_____

Which kind of emotional ailment are you dealing with at the moment?
Using the scale below, please rate the topics in range of importance according to your more
current feeling (from 0 as inexisting to 10 as unbearable):
anger _; hurry _;worry_ ; resignation_; beyond control_; lapse in concentration_; shame_; rigidity_; lack of self-confidence_; heightened sensibility _; heightened control_;anxiety_; social isolation_; sorrow_; awful mood _; fanaticism_; fear_; precipitation _;individualism_; selfishness_; hesitation_; exhaustion_; vulnerability_; suspiciousness_; heavy heart_; apathy_; dissatisfaction_;shyness _; dependence_; submission_; distraction _; camouflage_5; stress_.
In assessing your health it is helpful to have some sense of the degree of satisfaction you feel in various areas of your life. *Using the scale below, please rate your self in terms of satisfaction: 0*
means you are very unsatisfied, 10 means you are completely satisfied:
family_; friends__; relationships _; carreer__; physical environment__; health__; recreation__.
In the list below, underline all surgeries, accidents or traumatic events you have experienced:
• surgeries: adenoids, abdomen, heart, appendix, hernia, hemorrhoids, joint replacements, kidney
stones, gall stones, uterus, penis, prostate, hydrocele, cataract, other:_____
• trauma: any serious shock, grief, major disappointments, severe fright, nervous breakdown,
period of stress overload. Please describe and place a checkmark beside the event that continue to impact your life_____
_____

_____

• accidents: any accident or injury to the body or head?_____

Which vaccinations have you had? If you are unsure, please indicate with "?" diphtheria_;measles/mumps/rubella_;meningitis_;polio_;tetanus_;chickenpox_;Hepatitis ABC_; pertussis_;flu_; covid 19 and if yes, how many shots?: How many amalgam (silver) filling do you have _____ Have you ever had a reaction to a vaccine?_____

FAMILY HISTORY

please list family members' has had the following illnesses: use G for grandparent, P for parent and S for sibling

Abscesses ; Alcoholism ; Anemia ; Amnesia ; Arthritis ; Asthma ; Allergies ; Cancer ; Crohn's ; Colitis ; Diabetes ; Emphysema ; Epilepsy ; Eyes/sight problems ; Gall Stones ; Genital Herpes; Heart Disease ; High Blood Pressure ; High Cholesterol ; Hepatitis ; Lupus ; Lungs problems Mental Illness ; Migraines ; Miscarriage ; Multiple Sclerosis ; Obesity ; Osteoporosis ; Parkinson's ; Pelvic Inflammatory disease ;Strokes ; Rheumatic Fever ; Sinusitis ; Skin disease ; Spleen disease ; Thyroids problems ; Under Weight problems ; Prostate problems ;

What is the emotional climate of your home and work/school environment?_____

_____

_

EATING HABITS & DIETARY PATTERNS

Key: 0 = do not consume/use; 1= consume/use 2-3 times/month:
2 = consume/use weekly: 3= consume/use daily

__Alcohol __Artificial sweeteners __Candy, desserts, sugar __Fast foods __Fried foods __Cigarettes or vape __Cigars, pipes __Caffeinated beverages __Carbonated beverages __Lunch meats __Dairy __Vitamins/minerals __Baked goods __Dieting for weight control __Tap water __Distilled water __Charcoal filtered water

Are there any beverage, food or food groups that you avoid? (Y/N)

If yes, which one and why?_____

MEDICATIONS

Key: Place a checkmark beside the meds you have taken in the last month

__Antacids __Anti-anxiety Anticonvulsants _Antibiotics Antidepressants _Anti-fungals __Aspirin Ibuprofen __Tylenol __Beta blockers __Appetite suppressants __Chemotherapy __Cortisone Steroids Recreational drugs __ High blood pressure meds _Laxatives __Diuretics __Cholesterol-lowering __Diabetic medications/insulin __Pain Relievers __Viagra _Testosterone _Thyroid medications _Ulcer meds _Asthma inhalers _Sleeping pills

SUPPLEMENTS

How many supplements are you currently taking and for how long?

Underline those which were not prescribed (which you took the initiative to take)

_____

_____

UPPER GASTROINTESTINAL SYSTEM

Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily

__gas/belching within 1 hr after eating __sense of excess fullness after meals __ bad breath __heartburn/acid reflux__loss of taste for meat __stomach upset by vitamins __sweat has strong odour __anemia unresponsive to iron __sleepy after meals __feel like skipping breakfast __diarrhea, chronic __diarrhea shortly after meals __black/tarry coloured stools __undigested food in stool __feel better if you don't eat __fingernails chip/peel/break easily __stomach pains/cramps

MOVEMENT & NATURE

Type of activity & how many minutes do you spend exercising weekly?_____

How much time do you spend outdoors in natural sunlight daily?_____mins

COPING & DE-EXCITATION:
What specific activities do you use to transition out of "fight or flight" mode (e.g., meditation, hobbies, social connection, alcohol, mariuana, other)?_____

MORNING SPEED & FLUENCY METRICS:

Verbal Friction: [___] (1 = mixing up words/frequent pausing; 10 = fluid, effortless conversation).

1 to 10 Word-Recall Speed: [___] (how quickly names, nouns, or technical words come to mind?).

1 to 10 Working Memory Status: [___] (Do you often walk into a room and forget why? (Y/N).

SLEEP PATTERN, CIRCADIAN BIOLOGY & RECOVERY
Rate your sleep quality from 1 (poor) to 10 (excellent):__ Time it takes to fall asleep: _____mins; Number of nightly awakenings:__ Do you wake up feeling refreshed or chronically unrefreshed?_____

LIVER & GALLBLADDER
Key: 1= mild/monthly; 2 = moderate/weekly; 3 = severe/daily
_pain between shoulder blades _stomach upset by greasy foods
_ greasy or shiny stools nausea _ sea/car/airplane/motion sickness _history of morning sickness _light/clay coloured stools _dry/itchy/peeling skin _headache over eyes gallbladder attacks _bitter taste in mouth _become sick after wine _easily intoxicated if drink wine easily _hung over if drink wine _alcohol per week-amount : recovering alcoholic (Y/N) _history of alcohol/drug abuse (Y/N) history of hepatitis (Y/N)
sensitive to chemicals/perfumes (Y/N) sensitive to tobacco smoke (Y/N)
_pain under right side of rib cage _hemorrhoids/varicose veins _NutraSweet (aspartame) consumption _ chronic fatigue or fibromyalgia

SMALL INTESTINE
Key: 1= mild/monthly; 2=moderate/weekly; 3=severe/daily
__abdominal bloating 1-2 hrs after eating __specific foods make you tired/bloated __food allergies __pulse speeds after eating __airborne allergies __experience hives __crave bread or noodles __Crohn's disease __bizarre vivid dreams/nightmares __alternating constipation & diarrhea __asthma/sinus infections/stuffy nose __wheat/grain sensitivity __feel spacey or unreal __over the counter pain medications

LARGE INTESTINE
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
__anus itches __coated tongue __taken antibiotics for over 1 month __fungus/yeast infections __ring worm, jock itch, athlete's foot, nail fungus __less than one bowel movement per day __stools hard or difficult to pass __history of parasites (Y/N) __stools are not well formed (loose) __stools have corners/edges/flat/ribbon shaped __diverticulitis __cramping in lower abdomen __blood in stool __mucus in stool __excessive foul smelling lower bowel gas __dark circles under eyes __painful to press along outer thighs

ESSENTIAL FATTY ACIDS
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
experience pain relief with aspirin (Y/N) __crave fatty/greasy foods low/reduced fat diet (Y/N) __tension headaches at base of skull _headaches when out in the hot sun __muscles easily fatigued __sunburn easily __dry flaky skin/dandruff __fatty fish consumption

METABOLIC HEALTH
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
_crave sweets __binge/uncontrolled eating __excessive appetite __crave coffee/sugar in the afternoon __ sleepy in afternoon __fatigue that is relieved by eating __irritable before meals __awaken a few hours after falling asleep & difficult to get back to sleep __

__headache if meals are skipped/delayed __shaky if meals delayed __frequent thirst

MINERAL NEEDS
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
__bone loss (reduced density on bone scan) __calf/foot/toe cramps at rest __hoarseness __cold sores/fever blisters/herpes lesions __frequent skin rashes &/or hives __gag easily __frequent fevers __excessively flexible joints __dry mouth/eyes/nose __lump in throat __white spots on fingernails__pain/swelling in joints __deceased sense of taste/smell __morning stiffness __nausea with vomiting __history of carpal tunnel syndrome (Y/N) __crave chocolate __history of lower right abdominal pains __herniated disc (Y/N) __feet have a strong odour __history of anemia __whites of eyes blue tinted __history of bone spurs (Y/N) __difficulty swallowing __history of stress fracture (Y/N) __cuts heal slowly &/or scar easily __history of stress fracture (Y/N) __bursitis/tendonitis

NUTRITIONAL NEEDS
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
__muscles become easily fatigued __vulnerable to insect bites __loss of muscle tone __ringing in ears __feel exhausted/sore after moderate exercise __polyps, warts __depressed __heaviness in arms/legs __numbness/tingling/itchy hands __bleeding gums __enlarged heart/congestive heart failure __MSG sensitivity __fear of impending doom __worrier, apprehensive, anxious __nervous/agitated __can hear heart beat on pillow at night __nose bleeds &/or tend to bruise easily __night sweats __whole body/limb jerking as falling asleep __restless leg syndrome __cracks at corner of mouth __wake up without remembering dreams __small bumps on back of arms __strong light bothers eyes at night

ADRENALS
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 – severe/daily
__tend to be a night person __difficulty falling asleep __slow starter in the morning __headache after exercising __tend to be keyed up, trouble calming down _clench or grind teeth __feeling wired/jittery after drinking coffee __chronic low back pain, worse with fatigue __pain after manipulation __difficulty maintaining correction after manipulation *(ex.chiropractor)* __arthritic tendencies __become dizzy when stand suddenly __asthma, wheezing, or difficulty breathing __calm on outside, troubled on inside __crave salty foods __afternoon yawning __perspire easily allergies &/or hives __tendency to need sunglasses __weakness, dizziness _chronic fatigue, or get drowsy often __pain on the medial/inner side of the knee __tendency to sprain ankles/shin splints __allergies &/or hives

PITUITARY
Key: 1 = mild/monthy; 2 = moderate/weekly; 3 = severe/daily
__height under normal splitting type headach ___sexual development before age 10 __sexual development after age 13 __tolerate sugar, feel fine when eating sugar __memory failing __increased libidio __decreased libido __weight gain around hips/waist __excessive thirst __weight over normal __tendency to ulcers/colitis

THYROID
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
__mentally sluggish, reduced initiative __sensitive/allergic to iodine __fast pulse at rest __difficulty gaining weight __flush easily __inward trembling __constipation, chronic __intolerance to high temperatures __excessive hair loss &/or coarse hair __seasonal sadness __easily fatigued, sleep during the day __sensitive to cold, cold hands & feet __fast pulse at rest __difficulty losing weight __morning headaches/wear off during day __seasonal sadness __loss of lateral 1/3 of eyebrow __nervous, emotional, can't work under pressure

MEN ONLY
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily

__prostate problems __waking to urinate at night __pain/burning with urination
__difficulty with urination, dribbling __interruption of stream during urination
__difficult to start/stop urine __pain on inside of legs/heels __decreased sexual function
__feeling of incomplete bowel and/or bladder evacuation

WOMEN ONLY
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
__depression during periods __vaginal dryness night sweats (in menopausal females)
__intermittent menstrual flow __painful intercourse __mood swings associated with periods __crave chocolate around periods __vaginal discharge __occasional skipped periods
__breast tenderness associated with cycle __excessive menstrual flow__vaginal itchiness
__scanty blood flow during periods __gain weight around hips __excess facial/body hair
_variations in menstrual cycles __hot flashes __endometriosis __uterine fibroids __thinning skin
Are you currently pregnant (Y/NO) Planning to be pregnant (Y/N)
Are you currently on the birth control pill?(Y/N) Which brand?_____
How long have you been on the pill? Age of 1°period ___Last menstrual period_____
Have you ever suffered of breast fibroids, benign masses? (Y/N)

CARDIOVASCULAR
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
_aware of heavy &/or irregular breathing _ankles swell, especially at end of day
_dull pain/tightness in chest &/or radiated into right arm, worse with exertion
_discomfort at high altitudes cough at night _air hunger or sigh _frequently blush/face turns red for no reason _compelled to open windows in closed room _muscle cramps with exertion _shortness of breath with moderate exertion

KIDNEY & BLADDER
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
_pain in mid-back region _cloudy/bloody/darkened urine _urine has a strong odour
_puffy/dark circles around eyes _history of kidney stones (Y/N)

IMMUNE SYSTEM
Key: 1 = mild/monthly; 2 = moderate/weekly; 3 = severe/daily
_runny/drippy nose never get sick _catch colds at beginning of winter acne (adult)
_mucus producing cough itchy skin _frequent colds/flu cysts/boils/rashes
_other infections (sinus, ear, lung, skin, bladder, kidney, etc.)
_history of EBV, mono, herpes, shingles, chronic fatigue syndrome, hepatitis, or other
_chronic viral condition (Y/N)

Are there any other health concerns that you have which have not been covered in this Questionnaire?_____

Naturopathic services are provided for educational and complementary purposes and are not a substitute for professional medical advice, diagnosis, or treatment.

Date and signture_____

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