Judy Chambers RNCP, CPT
Holistic Nutrition & Personal Training
Suite # 6 - 2230 West 3rd Ave Vancouver, BC V6K1L4
Phone: (604) 250-9999 Fax: (604) 688-7557
www.dynamicbynature.com

General Medical History

CONFIDENTIAL

Please check boxes, circle or fill in where applicable

To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information will be kept confidential in your file.

Today's date: _____

Title: ❍ Dr. ❍ Mr. ❍ Mrs. ❍ Ms.

Name: _____ / _____ Birth date: _____

Last name First name Age: _____

Address: _____ Phone: (home) _____

City: _____ Phone: (work) _____

Province: _____ Postal Code: _____ Phone: (cell): _____

Email: _____ Occupation: _____

Reason for today's visit: _____

_____

Your family physician's diagnosis (if available): _____

How did you hear about the nutrition and personal training being offered by Dynamic by Nature / Judy Chambers? (Check all that apply)

- ❍ Friend Referral
- ❍ Core Passbook
- ❍ Internet
- ❍ Vancouver Yoga/Executive Lifestyles
- ❍ Doctor/Health Practitioner Referral
- ❍ Acubalance/Evolve
- ❍ Lecture/presentation/cooking class
- ❍ Other: _____

Medical History:

What forms of treatment/therapy do you currently use?

- ❍ M.D. (name and phone number): _____
- ❍ Physiotherapist
- ❍ Naturopath
- ❍ Psychologist/Mind-Body Therapist
- ❍ TCM Practitioner/Acupuncturist
- ❍ Massage Therapist
- ❍ Chiropractor
- ❍ Personal Trainer
- ❍ Other: _____

Have you worked with a holistic nutritionist before? ❍ Yes ❍ No

Have you used herbs &/or whole food supplements before? ❍ Yes ❍ No

Please print & complete. Be sure and bring with you to your appointment. Thank-you.

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Please indicate a "P", "C" or "F" if any of the health conditions below apply to you.

P= Past C= Current F= immediate Family history

____ Heart Condition	____ Respiratory Disorder	____ Headaches
____ Stroke	____ Kidney Disorder	____ Jaw Pain
____ High/Low Blood Pressure	____ Cancer	____ Arthritis
____ Diabetes	____ Hepatitis	____ Dizziness/Fainting
____ Deep Vein Thrombosis/Clot	____ AIDS	____ Contagious Illness
____ Neurological Condition	____ Sprain/Strain/fracture	____ Skin Condition
____ Spinal or Head Injury	____ Osteoporosis	____ Digestive Problems

Please list prescription drugs and/or over the counter medications you are currently taking.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Please list herbal medicines and other supplements you are currently taking.

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Please list any allergies you may have: (food, drugs, herbs and environment).

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Have you ever been hospitalized and/or treated for any infectious/serious condition or surgeries? ❍ Yes ❍ No

If yes, briefly explain for what condition or reason you were hospitalized and the year in which you were hospitalized: _____

Do you use the following? If so, how often? Cigarettes: _____ Alcohol: _____ Drugs: _____

Please check the physical activities you participate in, and how often per week.

❍ Yoga _____ ❍ Running _____ ❍ Fitness Class_____ ❍ Gym _____
❍ Biking _____ ❍ Swimming _____ ❍ Other _____

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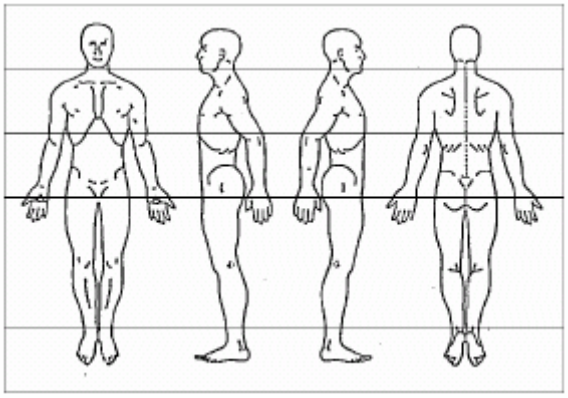
Please inform your practitioner if any of the following apply to you:

Hemophiliac	❍ Yes	❍ No	Epilepsy	❍ Yes	❍ No
Wear a pacemaker	❍ Yes	❍ No	Are you a vegetarian	❍ Yes	❍ No
Have a serious heart or lung condition	❍ Yes	❍ No	Do you have surgeries scheduled?	❍ Yes	❍ No
If you are taking anticoagulant medications	❍ Yes	❍ No	Are you pregnant or is there a chance you may be pregnant	❍ Yes	❍ No

On the figures below, please circle the areas of pain/concern:



Sensations/pain:

Sharp _____	Burning _____	Moves _____
Tingling _____	Dull _____	Severe _____
Shooting _____	Distending _____	Numbness _____

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____

What aggravates the pain? (weather, heat, cold, etc.)_____

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If you are currently experiencing any of these symptoms, or have been in the past three months, please check the appropriate circles.

Energy Levels

- ❍ Fatigue
- ❍ Weakness in the Limbs
- ❍ Lack of Stamina/Winded Easily
- ❍ Bodily Heaviness
- ❍ Lack of Muscular Strength
- ❍ Recent Changes in Weight (+/-)

Experience of Bodily Temperature

- ❍ Cold Hands & Feet
- ❍ Aversion to Cold or Heat
- ❍ Fever &/or Chills
- ❍ Excessive Perspiration w/ Exercise
- ❍ Cold Nose
- ❍ Feel Hot or Cold (full body)
- ❍ Spontaneous Sweating (w/o exercise)

Thirst

- ❍ Dry Mouth or Constant Thirst
- ❍ Prefer Warm Drinks
- ❍ Sip Small Amounts
- ❍ Absence of Thirst
- ❍ Prefer Cold Drinks
- ❍ Gulp Large Amounts

Appetite

- ❍ Normal/Healthy
- ❍ Poor Appetite
- ❍ Hungry but no Desire to Eat
- ❍ Ravishingly Hungry
- ❍ Need to Eat Several Meals
- ❍ Taste in Mouth _____

Digestion

- ❍ Nausea
- ❍ Acid Reflux/Heartburn
- ❍ Hiccup
- ❍ Bad Breath
- ❍ Vomiting
- ❍ Gas (Belching/Flatulence)
- ❍ Bloating
- ❍ Difficulty Swallowing or Lump in Throat

Urination

- ❍ Frequent Urination/Excessive
- ❍ Painful Urination
- ❍ Urgent Urination/Unable to Hold Urine
- ❍ Bedwetting
- ❍ Genital Lesions/Discharge
- ❍ Other _____
- ❍ Scanty Urination
- ❍ Blood in Urine
- ❍ Wake up to Urinate
- ❍ Painful or Itchy Genitalia
- ❍ Kidney Stones

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Stools

- ❍ Loose or Soft Stools
- ❍ Alternate Constipation/Loose Stools
- ❍ Mucous in Stools
- ❍ Black Stools
- ❍ Intestinal Pain or Cramping
- ❍ Rectal Pain or Fissures (broken skin)
- ❍ Constipation or Poor Elimination
- ❍ Laxative Use
- ❍ Undigested Food in Stools
- ❍ Bloody Stools
- ❍ Itchy or Burning Anus
- ❍ Hemorrhoids

Sleep

- ❍ Sound or Restful
- ❍ Heavy Sleep
- ❍ Insomnia
- ❍ Night Sweats
- ❍ Slow to Rise/Morning
- ❍ Light Sleep
- ❍ Difficulty Falling Asleep
- ❍ Dream Disturbed/Nightmares
- ❍ Wake Easily/Morning
- ❍ # Hours of Sleep/Night _____

Reproductive History

- ❍ Menstrual Cycle Regular
- ❍ Light Flow
- ❍ Menstrual Clots (dark red or purple)
- ❍ Mood Changes Prior &/or During Menses
- ❍ Headaches During Menses
- ❍ Pregnant # of months _____
- ❍ Miscarriage ____ Abortion ____
- ❍ Vaginal Discharge (color _____ odor _____ volume _____ texture _____)
- ❍ Pre-menopause
- ❍ Menstrual Cycle Irregular or Absent
- ❍ Heavy Flow
- ❍ Menstrual Flow Color (light, medium or dark)
- ❍ Cramps &/or Bloating During Menses
- ❍ Breast Tenderness Prior &/or During Menses
- ❍ Breastfeeding
- ❍ Birth Control (type _____)
- ❍ Post Menopause (hot flashes/mood swings etc…)

- ❍ Increased Libido
- ❍ Genital Discharge (Men)
- ❍ Decreased Libido

Discomfort or Pain

- ❍ Joint Pain
- ❍ Joints Crack
- ❍ Numbness or Tingling
- ❍ Chest Pain or Tightness
- ❍ Irregular or Slow Heart Beat
- ❍ Painful Varicose Veins
- ❍ Other _____
- ❍ Bodily Aches/Stiffness
- ❍ Difficulty Walking
- ❍ Backache &/or Knee Pain
- ❍ Heart Palpitations or Rapid Heartbeat
- ❍ Poor Circulation
- ❍ Swelling of Ankles

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Headaches & Dizziness

- ❍ Dizziness
- ❍ Fainting
- ❍ Headaches or Migraines (location _____)
- ❍ Other _____
- ❍ Blood Pressure (Low or High)
- ❍ Neck Stiffness

Bones, Teeth & Mouth

- ❍ Skeletal Bone Loss or Osteoporosis
- ❍ Tooth Decay or Oral Bone Loss
- ❍ Root Canals # _____
- ❍ Grind Teeth
- ❍ Bitter Taste in Mouth
- ❍ Bones or Teeth Break Easily
- ❍ Bleeding Gums
- ❍ Mercury Fillings
- ❍ Tongue or Mouth Canker Sores/Ulcers

Skin

- ❍ Acne
- ❍ Itching
- ❍ Hives
- ❍ Bruise Easily
- ❍ Fine Hair Falling Out
- ❍ Other: _____
- ❍ Eczema/Psoriasis
- ❍ Rashes
- ❍ Dry Flakey Skin
- ❍ Changes in Moles or Lumps
- ❍ Nails Break Easily or Flake Off

Eyes & Ears

- ❍ Blurred Vision
- ❍ Dry Eyes
- ❍ Red/Burning Itchy Eyes
- ❍ Spots/Floaters in the Field of Vision
- ❍ Poor Night Vision
- ❍ Other: _____

Respiratory & Throat

- ❍ Chronic Cough
- ❍ Coughing up Blood
- ❍ Wheezing/Asthma/Winded Easily
- ❍ Sinus Infections
- ❍ Recurring Sore Throat or Swollen Glands
- ❍ Coughing up Phlegm (color of phlegm _____)
- ❍ Difficulty Breathing/Shortness of Breath
- ❍ Nose Bleeds
- ❍ Frequent Colds

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Emotions & Memory

- ❍ Relaxed/Calm
- ❍ Over Thinking
- ❍ Sad
- ❍ Fearful
- ❍ Angry or Frustrated
- ❍ Depressed
- ❍ Poor Memory (long-term)
- ❍ Despondent/Lack of Will
- ❍ Stressed
- ❍ Anxious
- ❍ Grief
- ❍ Irritable Often or Easily
- ❍ Impatient
- ❍ Manic or Obsessive Compulsive
- ❍ Unable to Make Decisions
- ❍ Forgetful/Poor Concentration (short-term)

Other Concerns Not Labelled Above:

_____

_____

_____

_____

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Diet

Please describe in detail, your average daily diet, including meal times, preferred foods and amounts.

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages (*list all):

Glasses Water/Day ___ Cups Coffee/Day ___ Soda Pop/Week ___

Do you use any of the following foods or practices on a regular basis?
Artificial Sweeteners ___ Fast Food/Junk Food ___ Soy Protein/Soy Milk/Bragg's _____
Margarine/Refined Oils ___ Use of Microwave ___ Eat after 8 pm ____

Preferred Foods (*top three favourites): _____

Preferred Flavour: Sweet Salty Spicy Sour Bitter

Dislikes: _____

Lifestyle

Work: _____ hrs/week Normal Hours ____ Irregular Hours ____ Shift Work ____

Regular use of Stimulants (*cigarettes/alcohol/drugs) _____
Regular Exercise (*minimum 3 hrs/week) _____
Relaxation/Spiritual Activity (*weekly) _____
Occupational Stress (1= none … 10= unbearable) _____
Personal Stress (1= none … 10= unbearable) _____

What are you seeking from this consultation/session?

_____

What dietary or lifestyle changes would you like to make?

_____

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Client Information & Consent Form

Dynamic by Nature Ltd. offers educational and therapeutic sessions designed to develop strategies for personal wellbeing. These include nutrition and lifestyle support; personal fitness training; and self-reflection practices.

Consultations with Judy Chambers/Dynamic by Nature Ltd. do not include diagnosis or medical advice, and are intended to complement your doctor's treatment. Your physician can and should be advised of any information or recommendations discussed in these sessions.

Dynamic by Nature Ltd. advises that each client continue to seek the medical care of a licensed physician, if they are currently under the care of a licensed physician.

Statement of Consent

I hereby attest that I am here today and at any subsequent consultation/session, solely on my own personal behalf (and/or on behalf of my immediate family) to receive personal training and/or learn nutritional and lifestyle information, that I may choose to apply in my everyday life. I recognize that the services offered by Judy Chambers/Dynamic by Nature Ltd. do not involve medical diagnosis or treatment of any disease. I undertake full responsibility for my own wellbeing as it relates to these sessions.

Cancellation Policy

In signing this form, I also understand and accept that a fee of $75.00 (the full appointment fee) will be charged to my account if my cancellation or rescheduling is not done 24 hours prior to the date of my appointment, and Judy Chambers/Dynamic by Nature Ltd. is unable to fill that space.

_____ _____
Print name in full (*Print name of representative, if represented by another)

_____ _____
Signature (*Signature of Representative)

_____
Date

Please print & complete. Be sure and bring with you to your appointment. Thank-you.