

Sarnia Holistic Health Centre
546 Christina Street N. 6th Floor
Sarnia, Ontario N7T 5W6
519-336-7944
Rose Bridgeo, N.C.

HEALTH EVALUATION

Date: _____

Name _____ Age _____

Address _____ Date of Birth _____

City _____ Province _____ Postal Code _____

Tel. Nos.(for appt. confirmations) _____

Weight _____ Height _____ Natural Hair Colour _____ Eye Colour _____ Age _____

Email address: _____

Please check here **if you wish to receive an email with our monthly newsletter.**

What, if any, other program or direction and guidance have you received to date or are presently receiving to assist with your health? Medical or Natural Health Professional.

List any Vitamin , Mineral supplements or herbal or homeopathic remedies you are taking presently;

List any surgery you may have had

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Check any of the following conditions or medications you are taking;

Blood pressure - High _____ Low _____ Medication _____

Chronic Fatigue _____ Diabetes _____ Insulin _____ Headaches _____ Hypoglycemia _____

Fibromyalgia _____ Hormones _____ Laxatives _____ Heart Medication _____

Oral Contraceptives _____ Radiation _____ Chemotherapy _____ Steroids _____

Thyroid _____ Overactive _____ Underactive _____ Ulcer _____ Water Retention _____

Antacids _____ Antibiotics _____ Antidepressants _____ Anti inflammatory _____

MEDICATIONS: _____

OTHER CONDITIONS OR MEDICATION NOT MENTIONED please list: _____

WHICH OF THE FOLLOWING FOODS DO YOU CONSUME REGULARLY?

Dairy _____ Egg _____ milk _____ Cheese _____ Ice cream _____ Yogurt _____ creams _____

Breads _____ white _____ grain _____ wholewheat _____ other _____

Pasta _____ from white flour _____ from other flours _____

Fruits Raw _____ Fruits Cooked _____

Vegetables Raw _____ Vegetables Cooked _____

Legumes _____ Grains/raw _____ processed foods _____ Fish _____

Fats, deep fried foods _____ Oils _____ Butter _____

Condiments _____ Sauces _____ Gravies _____

Meats _____ Red _____ poultry _____ pork _____ lamb _____

Processed Meats: cold cuts _____ bacon, _____ smoked meats _____ sausages _____ hot dogs _____

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Soy/Soy Products _____ Alcohol _____ Coffee _____ Tea _____ Water/Day _____

Pop _____ Sweetened Juices _____ Unsweetened Juices _____ Natural Juices _____

Wine _____ Beer _____ Spirits _____

Do you have LOWER intestinal gas after eating? Yes _____ No _____

Do you have UPPER gas such as burping and belching after eating? Yes _____ No. _____

Heartburn Yes _____ No _____

Number of bowel movements per day, _____ colour _____ status=loose _____, hard _____ thin or pencil like _____, or other significant details _____

SLEEP PATTERN well _____ restless _____ insomnia _____, or other valuable

comments _____

Do you get colds or flus often? Yes _____ No _____. Once or twice per year? Yes _____ No _____

Do you recover quickly from ailments? Yes _____ No _____

Would you say your energy level is: Good _____ Not bad _____ Poor _____.

COMMENTS ON GENERAL FEELING OF WELL BEING good _____ great _____

depressed _____ sleepy _____ moody _____ light headed _____ spacey _____ dizzy _____

What is your present level of physical activity?

Additional comments related to your health

HOLISTIC NUTRITIONAL HEALTH PROGRAM WILL BE SPECIFICALLY DESIGNED FOR YOUR PERSONAL HEALTH NEEDS BASED ON THE INFORMATION YOU HAVE PROVIDED.

Rose A. Bridgeo / Holistic Nutritionist