Date: _____

Name: _____

biophilia
love your whole

Katherine M. Coleman
yoga & holistic life nutrition therapy

This form is designed to review your whole body, which includes where you are presently and the history that brought you here. Your body acts as a vessel into which food, air, and other substances, toxic/ harmful contaminants enter. There is no right or wrong answer. Please release any judgment that may emerge as you fill out this form: this is out of harms way.

General Information:

Address: _____ Date of Birth: _____

Please circle your preferred method of contact.

Phone: _____ Email: _____

Reason(s) for Appointment:

_____

_____

How would you describe your general health? _____

_____

What is your primary complaint? _____

_____

What are your symptoms? _____

_____

What instigates and/ or irritates your symptoms (consider environment, diet, & lifestyle)? _____

_____

Severity of Symptoms: ❍ Mild ❍ Moderate ❍ Severe ❍ Interferes with my daily life

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Age: _____ Height: _____ Weight: _____ Ethnicity: _____

Marital Status: ❍ Single ❍ Partnered ❍ Married ❍ Divorced ❍ Widow

Occupation: _____

Hours in a regular work week: _____

Please check appropriate occupational environmental conditions:

❍ Sitting ❍ Sitting +walking ❍ Computer (Hours/ day: _____) ❍ Fluorescent lighting

❍ Driving ❍ Lifting/ carrying ❍ Construction/ physical field conditions ❍ Fitness/ athletic

❍ Other: _____

Please list your regular physical activities, how often and the duration you're active: _____

_____

_____

_____

Please list your hobbies and/ or recreational activities, how often and the duration you're active: _____

_____

_____

_____

Please list your current stressors, from greatest stressor to least, and describe why:

_____

_____

_____

What time do you generally fall asleep? _____

How well do you sleep? _____

What time do you generally wake up? _____

Do you use an alarm? _____

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Health & Nutritional Habits/ History

Current weight: _____ Weight one year ago: _____ Birth weight: _____

Lowest Weight: _____ Highest Weight:_____ Desired Weight: _____

Have you recently gained/ lost weight? ❍ Yes ❍ No Was this change intentional? ❍ Yes ❍ No

Do you weigh yourself? ❍ Yes ❍ No How Often? _____

Are you concerned with your weight? ❍ Yes ❍ No Why or why not? _____

_____

How many times have you tried to lose weight?_____ Age of first attempt: _____ years

Your weight at that time: _____ lbs Reason for attempt? _____

How did you try to do it? _____

Were you successful? _____

Check the following you've used for weight control:

Commercial diet programs	❍	Liquid diets	❍
Prescription diet pills	❍	Fad Diets	❍
Over-the-counter diet pills	❍	Laxatives	❍
Diuretics	❍	Ipecac Syrup	❍
Self designed program	❍	Vomiting	❍

Other: _____

_____

Please check the following in which your partake, then list how much & how often:

❍ Tobacco: _____ ❍ Beer: _____

❍ Liquor: _____ ❍ Caffeine: _____

❍ Recreational Drugs (marijuana, cocaine, prescription, & psychedelics): _____

Describe any seasonal allergies you have: _____

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List your top ten favorite foods: _____

_____

List foods that you do NOT enjoy: _____

_____

List foods that you are allergic to: _____

Describe your average…

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Dessert: _____

How many times a week do you…?

❍ Eat fast food: _____ ❍ Shop in a grocery: _____ What store(s) & what is your weekly budget? _____

❍ Cook at home: _____ ❍ Eat at a restaurant: _____ Favorite(s)? _____

❍ Eat breakfast: _____ ❍ Eat in a car: _____

❍ Eat at work: _____ ❍ Drink coffee: _____

❍ Drink soda: _____ ❍ Have a bowel movement: _____

On a scale of one to ten (ten being the highest), how important is food cost? _____

Please check all that apply:

❍ Emotional eating ❍ Forget to eat ❍ Always hungry ❍ Mindless eating (i.e. eating while watching T\

❍ Don't know when to stop ❍ Fear of unhealthy food ❍ No joy in eating ❍ Love healthy food

❍ Eat out of necessity ❍ Confused by marketing health claims ❍ Lack of options/ lack of awareness

Have you been medically or self-diagnosed with an eating disorder? Please explain _____

_____

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Consider your Whole Digestion & Wellness

High Stomach Acidity	**Least/ Never**	**Light/ Rarely**	**Moderate/ Occasionally**	**Severe/ Constant**
Stomach burning/ aching 0-4 hours after a meal				
Stomach pain before meals				
Use of antacids (tums) for heartburn/ acid reflux				
Hungry an hour or two after eating				
Sudden, acute indigestion				
Temporary relief of pain by drinking milk, carbonated beverages				
Burping				
Bloating				
Use or previous use of pain medications (aspirin, ibuprofen, etc.)				
History or family history of ulcer or gastritis				

Low Stomach Acidity	**Least/ never**	**Light/ Rarely**	**Moderate/ Occasionally**	**Severe/ Constant**
Excessive belching/ burping/ bloating				
Gas right after a meal				
Foul breath				
Over-full-feeling after a meal				
Undigested food in stool				
Poor appetite				

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Low Stomach Acidity, continued	**Least/ never**	**Light/ Rarely**	**Moderate/ Occasionally**	**Severe/ Constant**
Known food allergies				
History of constipation				
Easily upset-stomach				

Colon/ Large Intestine Wellness	**Least/ never**	**Light/ Rarely**	**Moderate/ Occasionally**	**Severe/ Constant**
Lower abdominal pain, relieved by passing gas/ stool				
Alternating constipation & diarrhea				
Diarrhea				
Constipation				
Hard, dry, small stool				
Foul smelling stool				
Use of laxatives				
Frequent infections and/ or colds				
Yeast and/ or fungal infections				
Meat-eater (focus of most meals, 3x/ day)				
Recurrent stomach pains and aches				
History of antibiotic use				
Rapidly failing vision				
Family history of IBD				
Bladder and kidney infections				

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Blood Sugar Balance	**Least/ never**	**Light/ Rarely**	**Moderate/ Occasionally**	**Severe/ Constant**
Constant craving for sweets				
When a meal is skipped, you experience heart palpitations				
Irritable if a meal is missed				
Caffeine (coffee/ soda) dependent to in the morning and/ or afternoon				
Lightheaded, dizzy, and/ or shaky between meals				
Eating relieves fatigue symptoms				
Experience jitters and/ or tremors				
Easily upset/ anxious/ nervous/ agitated				
Forgetfulness and poor memory issues				
Wake up in the middle of the night and can't fall back asleep				
Middle of night snacking				
Often have unrealistic fears and/ or worries				
Fatigue/ sleepiness/ drowsiness after meals				
Eat sugar does not suppress desire for sweets				
Need dessert/ sugar after a meal				
Frequent urination				
Increased thirst and appetite/ always hungry				
Excessively weak for no apparent reason				
Moody and/ or depressed, roller-coaster emotions				

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Adrenal Function	**Least/ never**	**Light/ Rarely**	**Moderate/ Occasionally**	**Severe/ Constant**
Difficulty sleeping, constantly tossing & turning				
Craving for salt				
Difficulty waking up in the morning				
Lightness of head/ dizzy upon standing up				
Afternoon fatigue and/ or headaches				
Headaches upon exertions and/ or stress				
Weak and/ or rigid nails				
Slow to recover from colds, and often weak				
Poor circulation				
Susceptible to viruses, colds, asthma, bronchitis				
Difficulty failing asleep				
Frequent and/ or excessive perspiration				
Under severe amounts of stress				
Gain weight when stressed				
Feel drowsy even with seven+ hours of sleep				
Increased blood pressure				
Hot flashes				

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Thyroid Health	**Least/ never**	**Light/ Rarely**	**Moderate/ Occasionally**	**Severe/ Constant**
Lack of initiative, motivation, and/ or sluggish				
Constantly feeling cold hands, feet, and/ or whole body				
Need extra sleep at night, and/ or naps for proper functioning				
Hard to lose weight and/ or difficulty gaining weight				
Infrequency of bowel movements/ constipation				
Wake up with a headache, or have morning headaches that gradually digress				
Thinning of hair on face, scalp, genitals, or excessive amounts of hair loss				
Dry skin and/ or scalp				
Mental fatigue				
Ringing in ears or noises in brain				
Poor hearing				
Heart palpitations				
Increased pulse at rest				
Anxious and dramatic				
Insomnia				
Night sweats				
Easily flushed				
Can't handle hot weather				

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Please indicate whether you or a family member have/had any of the following conditions and describe protocol taken.

Disease/Condition	Self	Mother	Father	Grandparent	Description/ Treatment
Diabetes	❍	❍	❍	❍	_____
Kidney Disease	❍	❍	❍	❍	_____
Cardiovascular Disease	❍	❍	❍	❍	_____
Heart Attack	❍	❍	❍	❍	_____
Hypertension	❍	❍	❍	❍	_____
High Cholesterol	❍	❍	❍	❍	_____
Cancer	❍	❍	❍	❍	_____
Obesity	❍	❍	❍	❍	_____
Intestinal problems	❍	❍	❍	❍	_____
Menstrual problems	❍	❍	❍	❍	_____
Osteoporosis	❍	❍	❍	❍	_____
Food Allergies	❍	❍	❍	❍	_____
Food Intolerances	❍	❍	❍	❍	_____
Mental Health Issues	❍	❍	❍	❍	_____
Drug Dependency	❍	❍	❍	❍	_____
Asthma	❍	❍	❍	❍	_____
Headaches	❍	❍	❍	❍	_____
Other: _____	❍	❍	❍	❍	_____

_____

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Please list and describe medications and/ or supplements that are a part of your life in the box below.

Medications and/ or Supplements	**Amount**	**Frequency**	**Comments**

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