From Scratch Wellness Services
Jennifer Stanley, Traditional Naturopath
630-945-3867

NEW CLIENT INFORMATION

Name____ Today's Date________________________

Address____City_________________________

State_____Zip_____________ Home Phone________________________Work Phone___________________

Email Address_______________________________________Birthdate_________________Age___________

May we contact you by email to let you know of upcoming workshops and classes? Yes_____ No_______

Whom may we thank for referring you? ____

Height_____________Weight_____________Blood Pressure_________________Blood Type______________

What is the reason for your visit?____

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Do you have any primary health or emotional concerns?____

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Are you currently taking any prescription drugs? Which ones?____

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Are you currently taking any vitamins or herbal supplements? Which ones?_____________________________

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Do you eat sugar?_________Dairy?__________Meat?________________Fish?__________________________

Cigarettes?_______________Alcohol?____________Soda?___________Other substances?_________________

How many servings of raw fruit do you eat each day?________________________________

How many servings of raw vegetables do you eat each day?____________________________

On the back of this form please list your daily diet including drinks.

Last received vaccination?_________________________Last antibiotic?__________________________________

Do you have any allergies?____Stress?__________________

Do you bruise easily?______________Car accidents?____

Have you suffered major trauma in your life?____

Do you sleep well at night?____

Do you suffer from constipation or digestive issues?____

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I understand that all information shared in this visit is confidential and for educational purposes only and that it is not intended to replace your general medical practitioner.

Signed____Date________________________________