Integrated Body Health Nutritional Consultation

Name:_____ Date:_____

Do You Have A Regular Bowel Movement Before Noon Each Day? Yes: ☐ No: ☐
If No, how often do you go?_____ Diarrhea?: Yes ☐ No ☐

Do You Feel Rested?: Yes ☐ No ☐ How Much Sleep Per Night? _____(hrs)

What Time Do You Go To Bed? _____ Do You Wake Up in The Night?: Yes ☐ No ☐

What Time?_____ How Often? _____

Do You Wake Up To Go To The Bathroom?: Yes ☐ No ☐ Sometimes ☐

Do you take something to help you sleep?_____Name: _____

Do you exercise?_____ If so, what type and how often?_____ How

often are you outside in the sun?__Do you have a chlorine filter for your shower or bath?___ *List The*

*Three **Worst** Foods You Eat During The Average Week:*

1. _____ 2. _____ 3. _____

*List The Three **Healthiest** Foods You Eat During The Average Week:*

1. _____ 2. _____ 3. _____

Do You Smoke: Yes ☐ No ☐ | Times Per Day/Week: _____

How Much Water Do You Drink per Day? _____

Distilled: ☐ Spring: ☐ City Tap: ☐ Well: ☐

How many of these beverages do you consume per day?

Coffee: _____ Sweet Tea:_____ Green Tea: _____ Energy Drinks: _____Bottled Juice:_____
Soda:_____ Herbal Tea: _____ Black Tea:_____

Do You Use A Juicer? Yes ☐ No ☐ Alcohol Consumer per week?_____ Type:_____

How many times do you eat out per week? ____ How many servings fish per week? _____

How many times do you eat raw nuts or seeds per week? _____

Note:Please fill out this form and either Save/Email attachment to
pauline@integratedbodyhealth@gmail.com
or Print It and bring with you to your appointment.