Anne Schechter C.N.C.

Date: ________________________

Name: ____

Address: ____

Email Address: ____

Phone number: ________________________

Date of Birth: ____________________

Weight: __________

Height: __________

Married/Single: ____________

Please share your health concerns:

Have you ever received a medical diagnosis for this problem?

Was there an event that caused this concern?

Have you received treatment for this concern?

Any serious injuries or illnesses?

Are you menopausal?

YOUR MEDICAL HISTORY (circle all that apply and elaborate if possible)

Cancer
Autoimmune disease
Pain
Arthritis
Muscle pain
Muscle cramping
Chronic Pain
Fatigue
Chronic fatigue syndrome
Fibromyalgia
Acid reflux
Hernia
IBS
Celiac disease
Gallbladder issues
Diabetes
Weight imbalance
Concussion
Dizziness
Seizures
Tinnitus
ADD/ADHD
Memory loss
Insomnia
Heart disease
Cholesterol issue

Back pain
Constipation
Diarrhea
Nausea
Bloating or gas
Dental issues
Difficulty swallowing
GERD
Blood pressure imbalance
Stroke
Hepatitis
Fatty liver
Kidney disease
Kidney stone
UTI
Prostate condition
Frequent urination
Allergies
Anemia
Bruise easily
Asthma
Low immunity
Loss of hearing
Ear infections
Eye issues
Gout
Lyme disease

Hyper/Hypo thyroid

PMS

Vaginal infections

Hair loss

Acne

Skin issues

Cold sores

Canker sores

Sore throat

List medical concerns of immediate family:

Any history of addiction?

Please list any medications you currently take:

Please list any supplements you currently take:

Have you used antibiotics and if so, when?

Are you allergic to any medications or supplements?

Do you exercise?

Do you spend time outdoors?

Do you smoke?

Do you drink alcohol?

Do you drink coffee?

Have you ever been out of the country?

Rate your stress level on a scale of 1-10:

Do you have pets?

What is your occupation?

Do you sleep well?

How many hours per night?

What time do you go to bed?

What time do you wake?

Are you on any special diets?

Any dietary restrictions?

What are your cravings?

What are your favorite foods?

What foods do you dislike?

What is your food vice?

What percentage of your food is home cooked?

What percentage of your food is frozen or processed?

What percentage of your food is from a restaurant?

Describe a normal mealtime for you:

What are your health goals?

Anything else you would like to share:

Please Note:

If you need to get in touch with Anne, please call the front desk 763-537-5555

Phone Consultations are $3/min