



Harmony Heals, Inc

Date: _____

Name: _____

Best Phone number: _____

Birth date: _____

E-mail address: _____

Height: _____

Weight: _____

Please check the box if the question is a “yes” for you.

- You have chronic aches and pains, such as back and neck pain, headaches or general muscle or joint soreness? (circle which)
- You take an anti-inflammatory or anti-pain medication, such as ibuprofen, aspirin, or a similar prescription drug for pain, 2 or more times a week?
- You sometimes experience constipation? How often do you have a bowel movement _____?
- Your stools are often loose
- You experience heartburn/acid reflex. How often? _____.
- You take antacids fairly regularly (at least once a week.)
- You experience nausea after taking supplements?
- You sometimes experience bloating, gassiness, indigestion? How frequently _____
- You are prone to getting hemorrhoids
- You experience cramping in legs at rest
- You exercise regularly. Frequency _____ What form of exercise _____
- You are prone to colds, allergies and flu symptoms

- You have had a yeast infection. When was the last occurrence? _____
- You have taken an antibiotic in the past year.
- You crave sweets, especially when you are depressed or stressed.
- You are an anxious eater.
- You tend to put weight on in your middle-abdomen area
- You find it difficult to lose weight
- You find it difficult to keep your weight on.
- You are a smoker (if yes, how many packs do you smoke per day?) _____
- You find it difficult to fall asleep
- You wake up in the middle of the night or the wee hours of the morning and have difficulty falling back asleep.
- You usually wake during the middle of the night with the need to urinate.
- You find it difficult to lose weight even though your caloric intake is low.
- You have frequent skin rashes, irritations
- You have/had eczema
- You have skin breakouts/acne
- You have restless leg syndrome
- Your libido has changed in the past few years.
- Your energy level has changed in the past 6 months to a year.
- There is a lot of ongoing stress in your life.
- You have experienced heart palpitations
- You feel less excited about life now than you did 5 years ago?
- You have or have had toe fungus

You've had a root canal. When _____

Family History (includes you)

There is a history of depression

There is a history of bingeing and purging

There is a history of anorexia.

There is a history of high cholesterol

There is a history of Heart disease in

There is a history of Alzheimer's, Parkinson's,

There is a history of Cancer in your immediate family. Type_____.

There is a history of Diabetes

There is a history of Arthritis

There is a history of Alcoholism

There is a history of Drug addiction (including pain meds)

There is a history of Hypertension

History Osteoporosis

1. Do you drink Gatorade, sodas, energy drinks? _____ How many times a week?

2. On average, how many hours of sleep to you get nightly?_____

3. What time do you usually go to bed?_____

4. What time do you usually wake up?_____

5. How often would you say you eat out per week? _____

6. How frequently do you eat at a fast food restaurant? Daily_____,
weekly_____, monthly_____, a couple times a year_____,
Never_____.

7. Are you currently under a physician's care_____, Name_____?

When was the last time that you saw a physician?_____

8. Please list all prescription medications that you are currently taking.
_____.
9. Please list any supplements that you are currently taking_____
10. Do you experience any numbness or tingling in your extremities?_____
11. How many cokes, energy drinks or cups of coffee do you consume per day?

12. What time of day is your energy level usually the lowest? _____
13. Do you usually run colder than most of the people around you? _____
14. Is your blood pressure low, high or aver? _____
15. How much water do you typically drink per day? _____
16. Are you a practicing vegetarian_____? Vegan_____?
17. Have you ever had surgery?____ What type_____ and when_____.
18. Have you had any dental work in the past 3 years?_____ describe_____.
19. Are you married?_____
20. Amount of stress in your personal relationships on scale of 1-10_____.
21. What type of work do you do?_____.
22. Amount of stress related to work on scale of 1-10_____.
23. List at least 3-4 things that you do for fun_____.
- _____.
24. How do you relax._____.
25. How many hours of TV do you watch per day_____.
26. How many glasses of wine or cocktails do you enjoy weekly?_____
27. Type of work that you do _____

28. Do you have or have you ever had amalgam fillings? _____

If you have had them removed, when was this done? _____.

Women only

29. Is your hair dry or brittle? Are you losing hair?

30. Are you currently taking birth control pills? _____ For how long? _____

31. Are your periods normal? _____

32. Do you suffer from PMS? _____

33. Have your periods change within the last 6 months. _____

34. Do you have night sweats? _____

35. Do you sometimes experience incontinence? _____ How frequently? _____.

Men only

1. Do you have a frequent urge to urinate but not much comes out? _____

2. If you have had a PSA test when was it last done and what was your score? _____

What is it that you would like to ultimately achieve with nutritional counseling?

Informed Consent:

I _____ voluntarily consent to be counseled in regards to nutritional supplementation, dietary changes and possibly lifestyle changes.

I understand and agree that it is important to first consult with a health care professional before beginning to follow any dietary, supplement or exercise program. I understand that taking certain supplements can possibly interfere with some medications and that consulting with my doctor before taking any supplements is recommended. In particular, if currently taking psychotropic and/or antidepressant and anti-anxiety medications, or a sleep aid, I understand that I will need to consult, on a regular basis, with my current Doctor, if I decide to take amino acid supplements as they may conflict with or enhance these types of prescription medications.

I understand that Cindy Dupuie, of Harmony Heals, may recommend, based on information gathered from the client, supplements to possibly increase over all general well being. Neither Cindy Dupuie, nor anyone affiliated with Harmony Heals, claims to diagnose, treat, cure, or prevent any disease nor prescribes any pharmaceutical or medical treatments.

Payment is due at the end of each appointment. You will be responsible for payment of a cancelled appointment if cancellation is made in less than 24 hours from the scheduled appointment.

Signature _____ Date _____

24351 Moulton Pkwy Suite 120 Laguna Woods, Ca. 92637
Telephone (714) 897-1615, (949) 837-2751 & Fax (949) 586-5695