**Name: Email address:**

**Birthdate: Telephone:**

*Please fill out this form to your best ability and return to me before our consultation: micheleschulz@gmail.com*

*The information you share will remain confidential.*

1. Do you have any specific health issues that you would like to address through this consultation?

 If so, please briefly describe the ones that are currently the most problematic:

2. What have you tried so far to relieve or treat these concerns (i.e. therapies, remedies, supplements, consultations with a practitioner)?

3. Please keep a food journal for three full days, writing down everything you eat and drink and the times at which you do so. Please do this with a light spirit and without getting hard on yourself or inducing self-criticism. No secrets! Please include the journal when you send this form.

4. Are there specific foods that are problematic for you or for which you are intolerant or allergic to?

5. Are you currently taking any food supplements? Vitamins? Prescription medicine? If so, which ones?

6. What is your blood type?

7. Are you vegetarian or vegan?

8. Do you ever experience any one (or more) of the following:

 burning or heat sensations in your throat, esophogus or stomach

 bloating or gas

 feeling tired or sleepy immediately after eating (especically lunch)

 diarrhea

 constipation (if so, how many days without eliminating?)

 alternating diarrhea and constipation

 feelings of heaviness that last a while after meals

 abdominal cramps after meals

 intestinal pain linked to foods

 acidic or metallic taste in the mouth

 burning sensations in the mouth after having eaten citrus fruits

 acid reflux or taste of food in the mouth between meals

 burping outside of meals

 bad breath

 unhealthy body odors

 frequent or chronic fatigue

 allergies, sensitivities or food intolerances (i.e. gluten, lactose, casein)

 frequent or chronic sinus congestion

 frequent or chronic inflammation

 eczema, psoriasis or skin eruptions

 intolerance to fatty or oily food (such as certain meats, cold cuts, cheese, fried food)

 headaches after meals

 migraines

 ulcers

 gastritis

9. Is there anything else you'd like to share with me before our consultation? Are there any issues or questions you'd like to address during our time together?

10 Before our consultation, please look at your tongue using a mirror in order to describe to me what you see (lines that stand out, color, presence or absence of a coating, etc.)

*Thank you in advance, Michele*