

GENERAL INFORMATION SHEET

Name _____ Age _____ Sex: M F Date _____

Address _____

City _____ State/Prov. _____ Postal Code _____

Country _____

Home Phone _____ Business Phone _____

E-Mail Address _____ Height _____ Weight _____

Occupation _____ How were you referred? _____

What are your main health concerns or conditions? _____

Please list any medications or food supplements you are currently taking:

Please list any recent medical tests results you have, such as blood tests:

Please list illnesses in your family such as heart disease, cancer, TB, diabetes or arthritis.

DIET: What are examples of typical breakfasts for you?

Beverages

Mid-morning Snacks _____

What are typical lunches for you?

Beverages

Mid-afternoon Snacks _____

What are typical dinners for you?

Beverages

Evening Snacks _____

How often and what kind of exercise do you do? _____

About how many hours of sleep do you get per day? _____

I understand that nutritional balancing is a means to reduce stress and balance body chemistry. It is not intended as diagnosis, treatment or prescription for any condition or disease. Rosemary Slade is certified in Nutritional Balancing and has a degree in occupational therapy.

Signed _____

Date _____

Name _____ ***SYMPTOMS SHEET***

CIRCLE any conditions or symptoms that presently describe you.

PLACE A STAR next to the symptoms most important to you.

Joint Pain	Fungal Infections/Candida	Migraine Headaches
Joint Stiffness	Psoriasis	Neuritis
Arthritis, Osteo	Hives	Eye diseases
Arthritis, Rheumatoid	Hair Loss	Constipation
Muscle Pain	Slow Wound Healing	Diarrhea
Muscle Weakness	Cataracts	Intestinal Gas
Muscle Cramps	Glaucoma	Bloating
Bursitis	Meniere's Disease	Heartburn
Fractures	Tooth Decay	Ulcer
Osteoporosis	Excessive Plaque on Teeth	Stomach Pain
Gout	Gum Disease	Colitis
		Gall Stones
Sweet Cravings	Infections/Viruses	Fissures
Sugar Reactions	Tumors/Cancer	Hemorrhoids
Irritable before meals	Multiple Sclerosis	Cirrhosis
Can't Skip Meals	Parkinson's Disease	Diverticulitis
Hypoglycemia	Scleroderma	Tend to Gain Weight
Crave Starches	Fear	Tend to Lose Weight
Fat Cravings	Anger	
Other Food Cravings	Anxiety	Anemia
Food Allergies	Bipolar Disorder	Easy Bruising
Excessive hunger	Brain Fog	
No hunger	Confusion	Dental Amalgams
Diabetes	Depression	Drug Addiction
	Irritability	Alcoholism
Rapid Heart Rate	Mind Races	Smoking
Skipped Heart Beats	Mood Swings	
Heart Palpitations	Obsessive/Compulsive	WOMEN:
Heart Attack	Panic Attacks	Premenstrual Syndrome
Poor Circulation	Poor Memory	Water Retention
Dizziness	Schizophrenia	Cramps
Low or High Blood Pressure	Trouble Sleeping	No Menstruation
Angina	Suicidal thoughts	Heavy periods
Arteriosclerosis	Autism	Light/Irregular Periods
High Cholesterol _____	Attention Deficit	Ovarian Cysts
High Triglycerides _____	Hyperkinesis	Fibroid Tumors
	Dyslexia	Abnormal Pap Smear
Cough	Seizures	Menopause
Bronchitis	Learning Disability	Fibrocystic Breasts
Asthma	Mental Retardation	Breast Tumors
Post-nasal Drip	Delayed Development	Yeast Infections
Sinus Congestion		Hot Flashes
Allergies	Bladder Infections	Currently pregnant
Emphysema	Kidney Infections	Abuse
	Trouble Urinating	Rape
Fatigue	Frequent Urination	
Hypothyroidism	Painful Urination	MEN:
Low Body Temperature	Kidney Stones	Prostate Problems
Cold in Winter/Dry Skin	Water Retention	Impotence
Tend to Gain Weight	Kidney Stones	Infertility
Hyperthyroidism	Water Retention	
Acne	Sinus Headaches	
Eczema	Tension Headaches	

Other Symptoms or Comments: _____