*TheBodyCAN – New Client Form*

 Randi Shannon, Naturopathic Doctor

 Face/Tongue/Fingernail Analysis Expert

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Phone | Address | Other Phone |
| City | State/Zip | Email | Age |
| Height | Weight | Healthcare Coverage (Y/N) | If Yes, Provider Name |
| Male or Female | New / Returning |  |  Type of analysis you chose? |
| Weekly Movement | Type of Activity | Daily Water Intake | Type (RO/Tap/Spring/Distilled) |
| Meals Eaten Daily | Bowel Eliminations per Day | Urinary Frequency | Urinary Color |

What is your profession?

How many hours a week do you work?

What are your Symptoms/Relief Goals\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What types of food do you crave? Salty Sweets Breads Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your favorite foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Consumption Frequency -Circle what applies and how many daily monthly or yearly (d/m/y)

|  |  |
| --- | --- |
| Soda Pop | White Flour |
| Coffee | Sugar |
| Smoking | Raw Fruit |
| Alcoholic Beverages | Meat |
| Fast Food | Raw Veggies |
| Milk | Whole Grains |

## Health Concerns & Diagnoses

Circle or underline all that apply:

|  |  |  |
| --- | --- | --- |
| Acne | ADD/ADHD | Adrenal Fatigue |
| Allergies | Alzheimer’s Disease | Anemia |
| Anger/Irritability | Anxiety/Panic Attacks | Appetite Issues |
| Arteriosclerosis | Arthritis | Asthma |
| Autism Spectrum | Back Pain | Bad Breath |
| Bed Wetting | Bell’s Palsy | Bipolar Disorder |
| Bites/Stings | Bladder Issues | Blood Pressure (High) |
| Blood Pressure (Low) | Boils | Bone Health |
| Brain Fog | Breathing Difficulties | Bronchitis |
| Bruises | Burns | Cancer |
| Candida Overgrowth | Canker Sores | Carpal Tunnel |
| Cataracts | Chest Congestion | Chest Pain |
| Cholesterol Issues | Chronic Fatigue | Circulation Problems |
| Cold (Common) | Cold Sensitivity | Colic |
| Colon Issues | Constipation | Cough |
| Cravings (Unusual) | Dandruff | Depression |
| Diabetes | Diarrhea | Digestion Problems |
| Dizziness/Vertigo | Ear Infections | Ear Ringing (Tinnitus) |
| Eczema | Edema (Swelling) | Emphysema |
| Epilepsy/Seizures | Eyesight Issues | Fatigue |
| Fever | Fibromyalgia | Flu |
| Gallstones | Gangrene | Gas/Bloating |
| Gout | Gum Disease | Hair Loss/Thinning |
| Headache/Migraines | Heart Issues | Heartburn/GERD |
| Hemorrhoids | Herpes | Hiatal Hernia |
| Hives | Hormone Imbalance | Hyperactivity |
| Hypertension | Hyperthyroidism | Hypoglycemia |
| Hypothyroidism | Impotence | Incontinence |
| Indigestion | Insomnia | Joint Pain |
| Kidney Issues | Kidney Stones | Laryngitis |
| Leprosy | Leukemia | Liver Stress |
| Lung Issues | Lupus | Lymphatic Congestion |
| Menopause Symptoms | Menstrual Cramps/Irregularity | Mononucleosis |
| Mucous Excess | Multiple Sclerosis | Muscle Cramps |
| Nail Health | Nausea | Nervousness |
| Nosebleeds | OCD (Obsessive-Compulsive Disorder) | Osteoporosis |
| Parasites | Parkinson’s Disease | PMS (Premenstrual Syndrome) |
| Pneumonia | Polyps | Pregnancy Concerns |
| Prostate Issues | Psoriasis | Rash |
| Reproductive Health | Respiratory Issues | Rheumatism |
| Ringworm | Schizophrenia | Sciatica |
| Shingles | Sinus Problems | Skin Issues |
| Snoring | Sore Throat | Stomach Pain |
| Stress | Stroke | Sty |
| Suicidal Thoughts | Teething | Tennis Elbow |
| Tonsillitis | Tumors | Ulcers |
| Urinary Infections | Varicose Veins | Weight (Overweight) |
| Weight (Underweight) | Yeast Infections | Autoimmune Disorders |
| Celiac Disease | Chronic Inflammation | COPD (Chronic Obstructive Pulmonary Disease) |
| Crohn’s Disease | Dementia | Diverticulitis |
| Endometriosis | Epstein-Barr Virus | Fibroid Tumors |
| Gastritis | Guillain-Barré Syndrome | Hashimoto’s Thyroiditis |
| Hepatitis | Huntington’s Disease | Interstitial Cystitis |
| Lymphedema | Meniere’s Disease | Neuropathy |
| Scleroderma | Trigeminal Neuralgia  | Sickle Cell |

## Write any other information here that you want me to know.

## How much daily energy (1 = lowest energy level; 10 = highest energy level) do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any surgeries? Yes No If Yes, what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How many hours of TV do you watch daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of “you time” do you spend each day? (prayer, meditation, naps, church, reading, study, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours a week do you spend with family/friends?\_\_\_\_\_\_ Social? \_\_\_\_\_\_\_\_\_\_\_ Obligations? \_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you get each night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many hours do you need? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescription meds? Yes OR No If Yes, what/why/how long?

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## Who referred you for your appointment today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Agreement & Understanding

I understand that I am here to learn about food choices, lifestyle changes, and natural health practices. I acknowledge that Dr. Randi Shannon will offer assessments based on formal naturopathic training, including face, tongue, and fingernail analysis. I am not here for medical diagnoses, treatments, or prescriptions. I also understand that once I send pictures and/or this form there are no refunds as Dr. Shannon will have already begun her work.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_