core healing llc
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Medicines
Lifestyle

_____
Your first initial and last name

_____
Today's date

If available, please bring your most recent lab/blood work results to your first session.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

What medications are you currently taking?
(Prescription, birth control, hormones, recreational...)

What vitamins, herbs or supplements?

What over the counter medications are you taking?

- ☐ acetaminophen (tylenol)
- ☐ aleve
- ☐ allergy medication
- ☐ cough medicine
- ☐ ibuprofen (motrin, advil)
- ☐ anti-acids
- ☐ laxatives
- ☐ sleeping pills
- ☐ water pills
- ☐ weight reducing pills
- ☐ iron pills

Other: _____

Have you used anti-biotics?
If yes, date of last use: _____

Lifestyle

Do you smoke cigarettes or marijuana?	☐ Yes	☐ No	Equivalent of how many packs per day? _____
Do you drink coffee?	☐ Yes	☐ No	How many cups per day? _____
Do you drink alcohol?	☐ Yes	☐ No	How many drinks per day? _____
Do you drink soda or smart drinks?	☐ Yes	☐ No	How many cans and/or bottles per day? _____
Recreational drug use?	☐ Yes	☐ No	(Daily Often Occasionally Rarely)

_____ _____ _____
How many meals do you eat per day: Snacks per day: Water intake per day:

What foods, if any, do you have strong cravings/desires for?

Do you eat a special diet? If yes, please describe:

Do you have allergies or adverse reactions to food? If yes, please describe what and why:

Have you been tested for food or environmental allergies? If yes, what?

Do you get regular exercise? If yes, how often? What type?

Neurological/Psychological

- ☐ dizziness
- ☐ fainting and/or blackouts
- ☐ seizures and/or convulsions
- ☐ tingling and/or numbness
- ☐ problems walking
- ☐ lack of co ordination
- ☐ speech problems
- ☐ hard to concentrate
- ☐ indecisiveness
- ☐ anxiety
- ☐ worry often
- ☐ mood swings
- ☐ nervous breakdown
- ☐ depression
- ☐ SAD (seasonal affect disorder)