



# Nature Care College

## NATUROPATHY    NUTRITION    HERBAL MEDICINE CLIENT CASE TAKING FORM

Client name: \_\_\_\_\_ DOB: \_\_\_\_\_

Student Name: \_\_\_\_\_ Student #: \_\_\_\_\_

Clinic Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Attending: Naturopathy ☐      Nutrition ☐      Herbal Medicine ☐

### **PRESENTING SYMPTOMS**

(P++/sensation, location, duration, what was happening when presenting symptoms began, better by/worse by, current treatment etc.)

**PAST HISTORY** (Vaccinations, childhood illness, accidents etc)

**FAMILY HISTORY** (CVD, cancer, bowels, diabetes, liver disease)

*Please note if history is on mother's or father's side, siblings etc.*

**SLEEP** (How many hours per night, any problems, dreams, wake refreshed?)

**ENERGY** (0-10, any slumps, what time?)

**ALLERGIES / INTOLERANCES** (foods, alcohol, drugs, environmental)

What is the reaction like?

**MEDICATIONS & SUPPLEMENTS:**

**LIFESTYLE**

(Exercise, relaxation, job satisfaction, anxiety, depression, mood swings?)

## DIET

<b>BREAKFAST</b>	
Morning snack	
<b>LUNCH</b>	
Afternoon snack	
<b>DINNER/DESSERT</b>	

**Water:** \_\_\_\_\_

**Tea/Coffee:** \_\_\_\_\_

**Alcohol** (How does it affect you?): \_\_\_\_\_

**Cravings/Aversions:** \_\_\_\_\_

**How often do you eat out or get takeaway meals? Any specific preferences?**

\_\_\_\_\_

**What happens if you skip a meal?:**

\_\_\_\_\_

**What is your energy like after a meal?**

\_\_\_\_\_

**Do you eat when under stress / emotional eating (what type of food)?**

\_\_\_\_\_

**When cooking do you use fresh, canned, frozen and packaged foods?**

\_\_\_\_\_

## **BOWELS**

How often?; Do they feel 'empty' afterwards?; What do they look like/colour?; Is there any blood or mucous

## **PHYSICAL EXAMINATION**

(Observations: dandruff, hair, dark circles, skin, walking, sitting, tremors, smell?)

Nails: \_\_\_\_\_

Eyes: (Glasses/contacts, glare, night vision, swollen, infections, black shadows)

\_\_\_\_\_

Ears: (hearing too acute, waxy, noises, infections)

\_\_\_\_\_

Tongue:

\_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Pulse: \_\_\_\_\_

## **IRIS**

Colour: \_\_\_\_\_

ANW: \_\_\_\_\_

Texture: \_\_\_\_\_

Lesions: \_\_\_\_\_

GIT: \_\_\_\_\_

Lymph: \_\_\_\_\_

## **TREATMENT PROGRAMME**

## **STUDENT'S SUMMARY**