**Paula Youmell, RN**

*Functional Medicine RN – Natural Health Educator – Herbalist*

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Personal Health History:

1. **Return to me, filled out thoroughly, 2 business days before our appointment AND**
2. **Save as a word document only,** **NO PDF or Image files.**

Name:

Address:

Email address: Telephone: Home Cell

What brought you to call me / How did you know about me?

Do you have allergies to cats or dogs (I have 3 cats & 1 dog)? If so how severe?

Age: Height: Birth Date: Place of birth

Were you born via vaginal or c-section birth?

Current weight: Weight 6 months ago: One year ago

Are you happy with your weight? How would you like it to be different?

Based upon my [educational background & experiences](http://www.paulayoumellrn.com/meetpaula/), what type of support - education are you seeking from me?

What is your best learning style: audio, visual, hands on, or combo? Explain briefly please.

Your major health concerns?

Tell me 3 health symptoms (not conditions or diseases but body symptoms) that you would like immediate relief from.

When was the last time you felt vibrant and well? Why?

Rate current energy level on scale of 1 to 10. (1=lowest) What do you attribute this energy level to?

Other major life concerns?

Do you feel you have stress in your life? What?

What are your 3 top health goals?

If you could have one health symptom magically disappear which symptom would you chose?

What are your biggest assets working towards your health goals?

How will your life be better working towards these goals, having support, & achieving your goals?

If you could wave a magic wand and change 2 things in your life what would they be?

What do you do, for you, to work on your health and healing?

 How does your lifestyle choices augment or interfere with your well-being?

Do you smoke cigarettes? If so, how many?

Do you drink alcohol daily? If so, how much?

Have you ever smoked? If so, when, how much, for how long, & when did you quit?

Same questions for alcohol regular use or excess use.

Have you ever invested in your wellness? Y N What have you invested in to date?

Do you invest in the services of holistic healers, and if so, who?

What brought you to seek a holistic approach to your health & healing?

Are you in a relationship? How is that working for you?

**Pregnancies?** Pregnancy challenges?

Labors or delivery challenges?

Are/were your periods regular? Days of flow? How frequent?

Are periods painful or symptomatic in any way? Explain fully:

Are your reaching or approaching menopause? Please explain

Birth control history

Do you experience yeast infections?

Have you ever had a sexually transmitted disease? Herpes, Gonorrhea, chlamydia, vaginal warts, etc.

Vaginal infections?

Reproductive concerns?

Children, gender & ages?

Pets?

Occupation: Hours you work per week?

Are you happy with and at your job?

Any serious illnesses/hospitalizations/injuries?

Have you had any organs or glands removed (even parts of them removed)?

How is/was the health of your mother?

How is/was the health of your father?

**\*\*\*What is your ethnic ancestry? Blood type?**

Do you sleep well? How many hours? Dream nightly?

What time do you go to bed? Get up?

What is your pre-bedtime routine to get ready for sleep?

Do you wake up at night? How often? Why?

Do you get up with energy & relish the start of the day? Explain yes or no

Do you have pain, stiffness, swelling?

What color is your tongue? Pink or red?

Ongoing inflammatory issues? Eczema, skin irritation, chronic post nasal drip, congestion, headaches, migraines, achy joints/muscles, pain, stiffness? Please circle all that apply and explain if necessary.

To determine hot or cool body type: (this info helps to support food, herb, & lifestyle medicine recommendations)

* In general over your life, would you say you are a person who feels warm or cool (hot or cold) most of the time?
* Gravitate towards food, drink, environments that warm you up or cool you down?
* Are your hands & feet generally warm or cool?
* Feel better when you are on the edge of being too warm or too cool?
* Dry or moist (dry or oily skin & hair)?
* Gravitate towards choices that add moisture or dry you out? (Arizona vs. humid tropics?)
* Explain how these warm / cool, moist /dry may have changed over your life.

Bowel habits: constipation, diarrhea, gas, mucus in stools, etc. **Please explain specifically how many bowel movements you have daily.**

Urinary tract infections? Difficulty urinating or weak urine stream?

Allergies or sensitivities to foods, medications, environmental substances? Please explain

Medications you are on?

Supplements you take?

Over the counter medications you take on occasion OR regularly?

Have you ever had chemotherapy or radiation? For what and directed at what body area?

What meds have you taken for long periods of time but may be currently off them?

Do you receive vaccinations? Why?

Do you use sunscreen in summer?

Do you get sun time, without sun screen on your skin, in the summer?

Have you had your vitamin D level checked?

Do you have any current, last 6-12 months, lab work results to share? Please send me word document copies or print and bring with you to our session.

Were you on antibiotics frequently as a child? As an adult? When was the last time you took an antibiotic? Explain details if you can remember: ages, how often, why, how long a course?

Ever exposed to toxin in your home, job, environment, travel, etc?

General status of dental health?

Any troubling dental work, infections, root canals, dentures?

Silver/mercury fillings? How many?

Any dental care beyond regular cleanings?

What role does fitness/exercise/movement play in your life?

Common daily physical activities:

What are 3 things you do because YOU like to do them, fun things for you?

What do you do to relax? How often?

How was your general health & well-being as a child? Note any remarkable events.

Which emotions would you say dominate your life?

Any traumatic experiences in 5-7 years: death, divorce, job loss, serious injury, change of residence?

*For traumatic experiences below please be as specific as possible and include anything such as accidents, drug use (prescription, over the counter, and street drugs), abusive situations, traumatic acute illnesses, long term illnesses, family crisis, etc. Any trauma of mind, body, or your spirit. This is important in creating a timeline of your life to piece together possible precipitating events that can lead up to ill health symptoms.*

Any traumatic experiences in childhood?

Any traumatic experiences in your teen years?

Any traumatic experiences in older teen & young adult years?

Any traumatic experiences in adulthood?

Were you breast or formula fed as an infant? If formula fed, do you know if it was cow’s milk based or soy?

Did you ever experience a reaction to a childhood vaccine? If so what was the nature of the reaction and how mild or severe? A reaction to a vaccine as an adult?

What foods did you eat as a **child**? Give me a solid idea of typical breakfast, lunch & dinner foods as well as snack and liquids you drank on a regular basis:

breakfast:

lunch:

dinner:

snacks:

liquids:

Please do the same for your **adult eating habits**.

breakfast:

lunch:

dinner:

snacks:

liquids:

Do you regularly drink soda (soft drink), energy drinks, vitamin water, flavored/sweetened coffee drinks, etc?

Describe your general philosophy around choosing foods:

What types of food satiate you (make you feel comfy full and truly satisfy your hunger for several hours)?

* Carbohydrates? (whole grain breads, noodles, pastas, root veggies, etc.)
* Fats? (butter, avocados, fatty meat, nut butters, full fat dairy cheeses & yogurt, etc.)
* Proteins? (beans, nuts & seeds, meat, dairy, eggs, etc.)

Are there any foods you eat daily?

Foods you eat almost daily, 3-4 times weekly?

Foods you eat 2-3 times weekly?

Is your home water supply a personal well or town water? Is there chlorine or fluoride in the water?

Did you drink town/city water growing up or water from a home drilled well?

Do you have people in your life who will be supportive of your desire to change your health & lifestyle habits? Who?

What percentage of your food is home made? Do you cook? Where do you get the rest of your food?

Do you have cravings? Sweets/chocolate/coffee/salt/alcohol/cigarettes/drugs??

Any major addictions?

What are the 3 most important things you know you could change in regards to your food choices to improve your health?

What are the 3 most important things you know you could change in regards to lifestyle habits to improve your health?

How motivated are you to change your lifestyle to improve your health & prevent disease? Scales is 1 to 10 with 10 being highly motivated:

What are 3 things in your life that motivate you to get & stay healthy?

What are 3 health topics you want to learn more about?

If there is anything else you think is important to share with me (more detailed information about your eating habits, your health condition and concerns (regular headaches in the AM, achy joints on & off, sore muscles occasionally… things you might attribute to “oh, I’m just getting older…”), your habits for healing mind, body, and spirit), please add it on to the end of this form.

* **Please, before your appointment, FULLY read the Consultation Pre-Appointment Information**
* **Please sign the following self-responsibility contract of consent based upon this reading:**

Name: Date:

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