Welcome!

Congratulations on taking your first step for a better understanding of your body and your health! As a Traditional Naturopath, I address all life states – physical, mental, emotional and spiritual, as I belief is that when all states are balanced, your body can reach a deep state of relaxation and healing can take place.

My initial session is composed of three parts:
First part is designed to learn about you – your lifestyle and your challenges. We will talk about what you can do to help yourself including, but not limited to: Nutrition, Movement, Herbal Medicine, Body work, Hydrotherapy, Energy work, Sleep and Education.

Second part includes my unique session (Trad Em®) combined of Castor oil packs on abdomen and chest, Reflexology, Lymphatic massage on areas covered with castor oil while all embedded in Trance Mediumship Healing Energy. This session is designed to bring the nervous system to a very deep state of relaxation.

By the end of the session (part three), I will walk you through the signs showing in your feet reflexes following the reflexology (which is a gentle manipulation of areas in feet that correlate to internal organs). You will be able to understand what is happening in your body physically, emotionally, and mentally. In addition to your understanding, we will discuss tools and ideas on how to continue your work at home to promote your own health and healing.

Follow up sessions will be discussed at the initial session. Usually, they will be a Trad-em@ session, however, in specific cases they may be more extensive and become a Special condition session, which is a 2-hour session.

Thank you so much for allowing me to be part of your healing journey. Please do not hesitate to contact me with any questions or further information.

Anat Shlagman, Traditional Naturopath

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Date: _____

Intake Form

Name: _____ Date of Birth: _____
Address: _____
Primary Phone: _____ Home Phone: _____ Cell Phone: _____
Email address: _____
How did you hear about me?_____

***What is your major condition you would like to improve*?**

_____
When did you first notice this? _____
What brought it on? _____
Which activities aggravate the condition? _____
Is this condition getting progressively worse? ___Yes ___No
Please explain: _____
Does this condition interfere with: ___Work ___Sleep ___Daily routine?
Please explain: _____
What have you done to get relief? _____
Was this condition medically diagnosed? _____

***Are there any other conditions you would like to improve*?**

_____
When did you first notice this? _____
What brought it on? _____
Which activities aggravate the condition? _____
Is this condition getting progressively worse? ___Yes ___No
Please explain: _____
Does this condition interfere with: ___Work ___Sleep ___Daily routine?
Please explain: _____
What have you done to get relief? _____
Was this condition medically diagnosed? _____

Describe any recent stress you have experienced (i.e.: adjust to move, domestic changes, loss, career adjustment...accident or trauma to the body ….)

_____

_____

General Information – mark all that applies:

___Chronic fatigue ___ Tired upon rising ___ Activity make me tired ___ Exercise gives me energy
___Mental fatigue ___Chronic pain. Where? _____
___Weakness ___Headaches ___Migraines ___Insomnia ___Lack of concentration
___Cancer _____ Treatment _____
___Depression. How long? _____ Treatments _____
Weight: _____ ***Height:*** _____

How often do you exercise?

___ Once a week ___ 2-4 times per week ___more ___never

How would you define your work environment?

___Stressful ___Enjoyable ___Peaceful ___Toxicity in building ___Noisy ___Fluorescent lights

___Other: _____

Immediate family disease history – Mark all that applies:

___cancer -Type: _____

___arthritis ___diabetes type 1 ___ diabetes type 2 ___stroke ___heart attack ___kidney stones

___gallbladder stones ___blood cloths ___hypertension ___lung problems ___liver problems ___osteoporosis

___ gout ___Depression

Digestive System:

Outline your daily food intake:

Breakfast: _____

Morning snack: _____

Lunch: _____

Afternoon snack: _____

Dinner: _____

After dinner: _____

water: _____cups per day

What is your general feeling in the digestive system:

___bloating ___ irritable bowel ___constipation ___ diarrhea ___ loose stools ___heart burn ___lack of appetite

___ binging ___ things taste funny

___allergies: _____

___cravings:_____

How many Bowel movements do you have weekly?_____

How many times do you feel bloated in a week? _____

How many times do you feel cramps in your digestive tract in a week? _____

How many times do you experience acid reflux in a week? _____

*Have you ever had any of these conditions – Key: **P** = Past and **C** = Current*?

___colitis ___Crohn's Disease ___irritable Bowel Syndrome ___Acid Reflux ___Ulcers ___Gallstones ___Hemorrhoids

___Food poisoning ___Polyps ___Diverticulitis ___Parasites ___Recurring Diarrhea

___heartburn ___Abdominal Pain ___Recurring Constipation ___Gastritis ___ Appendicitis ___Recurring Gas or Bloating

___rectal bleeding ___Colon Cancer ___Intestinal Infection ___ Hernia

Other concerns _____

Please mark how many times you eat or drink the following foods/drinks:

Food	Every day	2-4 times a week	Once a week	Once a month	Never
Eggs, meat, poultry, fish, dairy foods					
Vegetables, soups					
Coconut, coconut oil, olive oil, butter					
Fruits, dried fruits					
Potato, yams, white rice					
Pizza, bread sticks, Pancakes, waffles, Muffins, cookies, cakes, cupcakes, m&m, skittles, snicker, pretzels, veggie straws, chips, toasts, pita, sandwiches, spaghetti, Mac & cheese, lasagna, Energy bars / Granola bars, Cereals, peanut butter					
Margarine, Crisco, vegetable oils					
Restaurants, fast foods, ready frozen meals					
Water – how many cups? _____ Coffee, tea – how many cups? _____					
Alcohol, pop drinks, energy drinks – how many? _____					
Soy Products					
Other: _____					

Respiratory –Mark all that applies:

___Shortness of breath when standing or walking ___ tobacco smoking ___sometimes wakes up choking or gasping for breath ___yawns frequently ___frequent chest colds ___Allergies ___Asthma ___Bronchitis ___Frequent Colds/Flu ___Sinusitis __Other_____

Lymphatic – Mark all that applies:

___recuperates slowly ___ recuperates fast form ill ___ injury heal quickly ___ injury heal slowly

___eczema / dermatitis ___digests fats easily ___ digests fats poorly

___other _____

Endocrine –Mark all that applies:

Adrenal:___Sensitive to bright light ___ Low blood pressure ___Crave salt ___Dark circles under your eyes

Hypo Thyroid: ___Chronic fatigue ___Cry easily ___Suffer from PMS ___Swollen tongue

Hyper Thyroid:___Insomnia ___Bulging, swollen eyes ___Difficult to relax

Hypo Glycemic:___Fatigued if meal is missed ___Wakeup at night feeling hungry ___Hungry for sweets

Hyper Glycemic:___Frequent urination ___Excessive thirst ___Cuts that will not heal

Pituitary:___Chronic headaches at the level of the eyes ___Cold all over ___Overweight at hips

Thymus:___Chronic swollen glands in neck, groin, armpits ___Very susceptible to lasting infections

Pineal:___Lack of coordination in dark ___Symptoms worsen at night ___Irregular sleep habits

___Other_____

Cardiovascular – Mark all that applies:

___ active ___ sometimes dizzy or faint ___warm hands/feet ___ sweaty hands/feet ___cold hands/___anemia
___other _____

recent blood pressure reading: _____

Skin – Mark all that applies:

___Burns ___Dermatitis ___Dryness ___Eczema ___Fungal Infection ___Hives ___Impetigo ___Psoriasis
___Rash ___Scars ___ Warts ___Other_____

Skeletal muscular – Mark all that applies:

___Arthritis ___Artificial Joint ___Bursitis ___Carpal Tunnel Syndrome ___Joint Pain ___TMJ
___Muscular Dystrophy ___Osteoporosis ___Plantar Fasciitis ___Scoliosis ___Tendonitis ___Whiplash
___ Back pain ___Shoulder/neck pain ___Spasms/cramps
___Weakness – where? _____
___Other_____

Nervous– Mark all that applies:

___Anger/Irritability ___Anxiety/Fear ___Depression ___Grief/Sadness
___Worry/Over thinking ___Sleep Disorders ___ADD/ADHD ___Sciatica ___Alzheimer's ___Multiple Sclerosis
___Parkinson's Disease ___Seizures ___Shingles (herpes zoster) ___Spinal Cord Injury ___Cerebral Palsy ___Stroke
___Other_____

Immune – Mark all that applies:

___Chronic Fatigue Syndrome ___Diabetes ___Edema ___Fibromyalgia ___HIV/AIDS ___Lupus ___Lymphoma
___Cancer ___ Lyme
___Other_____

Urinary – Mark all that applies:

___dark colored urine ___smelling urine ___blood in urine ___excessive urination ___urination at night
___burning/pain on urination ___incontinence ___kidney stones ___UTI
___Other_____

Men Reproductive – Mark all that applies:

___Blood or pus in urine ___Increase urinary frequency ___Need to urinate during the night
___ Loose or diminished sex drive ___Unusual discharge from penis ___Itchy genitals
___Other_____

Women Reproductive:

Are you: ___ pregnant (# of weeks _____) ___ in menopause ___ post menopause
# of pregnancies: ____# of miscarriages: ____Birth control:_____
Is your cycle regular? ___Yes ___No
How is your flow? ___Heavy ___Light ___moderate
What is the quality of the blood? ___Congealed/clots ___Watery/thin ___Normal ___Other_____
Do you experience symptoms of PMS? ___No ___Yes: Symptoms: _____
0ther: _____

Surgeries / Medical interventions:

_____
_____
_____
_____
_____
_____

Please list any medications you currently are taking:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Please list any herbs, minerals, supplements you currently are taking:

Herb: _____ Reason: _____

Herb: _____ Reason: _____

Herb: _____ Reason: _____

Herb: _____ Reason: _____

Herb: _____ Reason: _____

Please list any other concerns you would like to address in this visit:

_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____