



Judy Chambers RNCP, CPT
 Holistic Nutrition & Personal Training
 Phone: (604) 250-9999
www.dynamicbynature.com

Please indicate a "P", "C" or "F" if any of the health conditions below apply to you.

P= Past C= Current F= immediate Family history

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Respiratory Disorder | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> Deep Vein Thrombosis/Clot | <input type="checkbox"/> AIDS | <input type="checkbox"/> Contagious Illness |
| <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Sprain/Strain/fracture | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Spinal or Head Injury | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Digestive Problems |

Please list prescription drugs and/or over the counter medications you are currently taking.

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Please list herbal medicines and other supplements you are currently taking.

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Please list any allergies you may have: (food, drugs, herbs and environment).

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

Have you ever been hospitalized and/or treated for any infectious/serious condition or surgeries? Yes No

If yes, briefly explain for what condition or reason you were hospitalized and the year in which you were hospitalized: _____

Do you use the following? If so, how often? Cigarettes: _____ Alcohol: _____ Drugs: _____

Please check the physical activities you participate in, and how often per week.

- Yoga _____ Running _____ Fitness Class _____ Gym _____
 Biking _____ Swimming _____ Other _____

Please inform your practitioner if any of the following apply to you:

302- 1245 West Broadway, V6H 1G7

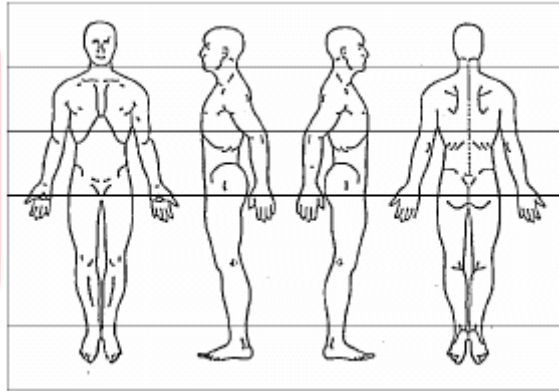


Judy Chambers RNCP, CPT
 Holistic Nutrition & Personal Training
 Phone: (604) 250-9999
www.dynamicbynature.com

Hemophiliac Yes No
 Wear a pacemaker Yes No
 Have a serious heart Yes No
 or lung condition
 If you are taking Yes No
 anticoagulant medications

Epilepsy Yes No
 Are you a vegetarian Yes No
 Do you have surgeries Yes No
 scheduled?
 Are you pregnant or Yes No
 is there a chance you may be pregnant

On the figures below, please circle the areas of pain/concern:



Sensations/pain: Sharp _____ Burning _____ Moves _____
 Tingling _____ Dull _____ Severe _____
 Shooting _____ Distending _____ Numbness _____

What relieves the pain (heat/cold/massage/rest/exercise, etc.)? _____

What aggravates the pain? (weather, heat, cold, etc.) _____



Judy Chambers RNCP, CPT
Holistic Nutrition & Personal Training
Phone: (604) 250-9999
www.dynamicbynature.com

If you are currently experiencing any of these symptoms, or have been in the past three months, please check the appropriate circles.

Energy Levels

- Fatigue
- Weakness in the Limbs
- Lack of Stamina/Winded Easily
- Bodily Heaviness
- Lack of Muscular Strength
- Recent Changes in Weight (+/-)

Experience of Bodily Temperature

- Cold Hands & Feet
- Aversion to Cold or Heat
- Fever &/or Chills
- Excessive Perspiration w/ Exercise
- Cold Nose
- Feel Hot or Cold (full body)
- Spontaneous Sweating (w/o exercise)

Thirst

- Dry Mouth or Constant Thirst
- Prefer Warm Drinks
- Sip Small Amounts
- Absence of Thirst
- Prefer Cold Drinks
- Gulp Large Amounts

Appetite

- Normal/Healthy
- Poor Appetite
- Hungry but no Desire to Eat
- Ravishingly Hungry
- Need to Eat Several Meals
- Taste in Mouth _____

Digestion

- Nausea
- Acid Reflux/Heartburn
- Hiccup
- Bad Breath
- Vomiting
- Gas (Belching/Flatulence)
- Bloating
- Difficulty Swallowing or Lump in Throat

Urination

- Frequent Urination/Excessive
- Painful Urination
- Urgent Urination/Unable to Hold Urine
- Bedwetting
- Genital Lesions/Discharge
- Other _____
- Scanty Urination
- Blood in Urine
- Wake up to Urinate
- Painful or Itchy Genitalia
- Kidney Stones



Judy Chambers RNCP, CPT
 Holistic Nutrition & Personal Training
 Phone: (604) 250-9999
www.dynamicbynature.com

Stools

- Loose or Soft Stools
- Alternate Constipation/Loose Stools
- Mucous in Stools
- Black Stools
- Intestinal Pain or Cramping
- Rectal Pain or Fissures (broken skin)
- Constipation or Poor Elimination
- Laxative Use
- Undigested Food in Stools
- Bloody Stools
- Itchy or Burning Anus
- Hemorrhoids

Sleep

- Sound or Restful
- Heavy Sleep
- Insomnia
- Night Sweats
- Slow to Rise/Morning
- Light Sleep
- Difficulty Falling Asleep
- Dream Disturbed/Nightmares
- Wake Easily/Morning
- # Hours of Sleep/Night _____

Reproductive History

- Menstrual Cycle Regular
- Light Flow
- Menstrual Clots (dark red or purple)
- Mood Changes Prior &/or During Menses
- Headaches During Menses
- Pregnant # of months _____
- Miscarriage ____ Abortion ____
- Vaginal Discharge (color _____ odor _____ volume _____ texture _____)
- Pre-menopause
- Increased Libido
- Genital Discharge (Men)
- Menstrual Cycle Irregular or Absent
- Heavy Flow
- Menstrual Flow Color (light, medium or dark)
- Cramps &/or Bloating During Menses
- Breast Tenderness Prior &/or During Menses
- Breastfeeding
- Birth Control (type _____)
- Post Menopause (hot flashes/mood swings etc...)
- Decreased Libido

Discomfort or Pain

- Joint Pain
- Joints Crack
- Numbness or Tingling
- Chest Pain or Tightness
- Irregular or Slow Heart Beat
- Painful Varicose Veins
- Other _____
- Bodily Aches/Stiffness
- Difficulty Walking
- Backache &/or Knee Pain
- Heart Palpitations or Rapid Heartbeat
- Poor Circulation
- Swelling of Ankles



Judy Chambers RNCP, CPT
Holistic Nutrition & Personal Training
Phone: (604) 250-9999
www.dynamicbynature.com

Headaches & Dizziness

- Dizziness
- Fainting
- Headaches or Migraines (location _____)
- Other _____
- Blood Pressure (Low or High)
- Neck Stiffness

Bones, Teeth & Mouth

- Skeletal Bone Loss or Osteoporosis
- Tooth Decay or Oral Bone Loss
- Root Canals # _____
- Grind Teeth
- Bitter Taste in Mouth
- Bones or Teeth Break Easily
- Bleeding Gums
- Mercury Fillings
- Tongue or Mouth Canker Sores/Ulcers

Skin

- Acne
- Itching
- Hives
- Bruise Easily
- Fine Hair Falling Out
- Other: _____
- Eczema/Psoriasis
- Rashes
- Dry Flakey Skin
- Changes in Moles or Lumps
- Nails Break Easily or Flake Off

Eyes & Ears

- Blurred Vision
- Dry Eyes
- Red/Burning Itchy Eyes
- Spots/Floaters in the Field of Vision
- Poor Night Vision
- Other: _____

Respiratory & Throat

- Chronic Cough
- Coughing up Blood
- Wheezing/Asthma/Winded Easily
- Sinus Infections
- Recurring Sore Throat or Swollen Glands
- Coughing up Phlegm (color of phlegm _____)
- Difficulty Breathing/Shortness of Breath
- Nose Bleeds
- Frequent Colds



Judy Chambers RNCP, CPT
Holistic Nutrition & Personal Training
Phone: (604) 250-9999
www.dynamicbynature.com

Emotions & Memory

- Relaxed/Calm
- Over Thinking
- Sad
- Fearful
- Angry or Frustrated
- Depressed
- Poor Memory (long-term)
- Despondent/Lack of Will
- Stressed
- Anxious
- Grief
- Irritable Often or Easily
- Impatient
- Manic or Obsessive Compulsive
- Unable to Make Decisions
- Forgetful/Poor Concentration (short-term)

Other Concerns Not Labelled Above:



Judy Chambers RNCP, CPT
 Holistic Nutrition & Personal Training
 Phone: (604) 250-9999
www.dynamicbynature.com

Diet

Please describe in detail, your average daily diet, including meal times, preferred foods and amounts.

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages (*list all):

Glasses Water/Day ____ Cups Coffee/Day ____ Soda Pop/Week ____

Do you use any of the following foods or practices on a regular basis?

Artificial Sweeteners ____ Fast Food/Junk Food ____ Soy Protein/Soy Milk/Bragg's ____
 Margarine/Refined Oils ____ Use of Microwave ____ Eat after 8 pm ____

Preferred Foods (*top three favourites): _____

Preferred Flavour: Sweet Salty Spicy Sour Bitter

Dislikes: _____

Lifestyle

Work: _____ hrs/week Normal Hours ____ Irregular Hours ____ Shift Work ____

Regular use of Stimulants (*cigarettes/alcohol/drugs) _____

Regular Exercise (*minimum 3 hrs/week) _____

Relaxation/Spiritual Activity (*weekly) _____

Occupational Stress (1= none ... 10= unbearable) _____

Personal Stress (1= none ... 10= unbearable) _____

What are you seeking from this consultation/session?

What dietary or lifestyle changes would you like to make?



Judy Chambers RNCP, CPT
 Holistic Nutrition & Personal Training
 Phone: (604) 250-9999
www.dynamicbynature.com

Client Information & Consent Form

Dynamic by Nature offers educational and therapeutic sessions designed to develop strategies for personal wellbeing. These include nutrition and lifestyle support; personal fitness training; and self-reflection practices.

Consultations with Judy Chambers/Dynamic by Nature Ltd. do not include diagnosis or medical advice, and are intended to complement your doctor’s treatment. Your physician can and should be advised of any information or recommendations discussed in these sessions.

Dynamic by Nature advises that each client continue to seek the medical care of a licensed physician, if they are currently under the care of a licensed physician.

Statement of Consent

I hereby attest that I am here today and at any subsequent consultation/session, solely on my own personal behalf (and/or on behalf of my immediate family) to receive personal training and/or learn nutritional and lifestyle information, that I may choose to apply in my everyday life. I recognize that the services offered by Judy Chambers/Dynamic by Nature Ltd. do not involve medical diagnosis or treatment of any disease. I undertake full responsibility for my own wellbeing as it relates to these sessions.

Cancellation Policy

In signing this form, I also understand and accept that a fee of \$85.00 (the full appointment fee) will be charged to my account if my cancellation or rescheduling is not done 24 hours prior to the date of my appointment, and Judy Chambers/Dynamic by Nature Ltd. is unable to fill that space.

 Print name in full

 (*Print name of representative, if represented by another)

 Signature

 (*Signature of Representative)

 Date