For Women
Dr. Sonia's Food Wisdom/Therapy

Complementary Health an Art of SelfHealing

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Your response to the following questions will empower you and me to design a personalized lifetime approach for a healing plan that will meet your needs for a complementary, natural approach to the physical, biological and psychological changes that affect you.

Today's Date: _____ Gender F ❒ M ❒
Name:_____ Birth Place_____
Address: _____
Home phone_____ Work #_____fax or email_____
Date of Birth_____19___ Social Security #_____
occupation_____ Education_____
Employer name, address and telephone_ _____phone
_____
Insurance Companies_____
Referring doctor or if any_____ phone:_____
Address_____

Highest level of education _____ Occupation _____

Marital Status; ❒ Married ❒ Single ❒ Long term significant relationship
Number of children____ Did you breastfeed? Yes___ How long____ No____
Persons who live with you and socioeconomic status

Please indicate which group most closely describes you
a. Asian or pacific Island
b. Hispanic (including Mexican-American and others)
c. Black d. Middle Eastern
e. European f. White g. Other_____
Did you live in any other country previously?_____
Parent's type of profession and socio-economic status, their relationship with you

Your hubby, special passions or strong interests

Anthropometric measurements*:*
Current Weight _____lbs. Height ____ Hip___ Chest ____
Waist____ Thighs Triceps ____ % frame: Sml ❒ Med ❒ Lrg ❒

Body Fat %_____ Electrolyte % Muscle Mass___ and Fat in lbs___
What is your desirable or healthy weigth?_____
How long have you been at your current weight ?_____
How many pounds do you want to lose _____ or to gain weekly ____
List the previous weight or eating disorder programs and what was the result?
_____
What do you think are the causes of your weight problem?_____
_____

PERSONAL MEDICAL/NUTRITIONAL HISTORY AND DATA

Chief Health Concerns or Complains that you would like to deal with during this consultation

Any Treatments for above Concerns

Do you have any nutritional problem? Yes___ No____
If yes, What?_____

Any nutritional problem you consider have had in your childhood to pregnancy etc. to the present time.

*What **medication** (s) do you take?_____*
Laboratory test result & date if known or you may rate on **High Low and Normal**
FSH____Estrogen_____Progesterone____ DHEA___ Glucose ____
Choles_____ LDL_____ HDL____ Bone Density_____
Other Mineral or Vitamins deficiency _____
Have you ever tested for Toxicity, intestinal parasites, and candida if yes, indicate the result?.

Family Medical History

-- check below if immediate family members have had:
Cancer_____ what type?_____ Heart disease _____ Hypertension_____
Osteoporosis ____ Diabetes _____ Hypoglycemia_____Obesity ____
Depression _____ or other mental illness_____
Addiction_____ Allergies _____ Asthma_____
Autoimmune problems (thyroid, lupus, rheumatoid arthritis, etc.) _____
other_____Please show current ages of family mentioned above or age at death_____

Please indicate how any of the following concerns or symptoms apply to you currently: rate symptoms or concerns on a scale of 0(no symptom) to 5 (very symptomatic).

Worry about aging? _____ Worry about gaining weight? ____ Feeling fatigue? ___
Feeling low energy? ___ Tiredness ?____ Craving for sweets? ____Joint pain? ____
Constipation?____ Experience bloating or gas?___ Feeling indigestion? ___

Difficulty of breathing?___ Loss of appetite? ____ Night sweating? ____ Difficulty sleeping?___ Waking up tired? ___ Interrupted sleep?___ Bad dreams ?___ Low mental concentration?___ Forgetfulness ?__ Fuzzy thinking ?___ Moodiness ?___ Frustrated? ___ Misplaced anger? ___ Anxiety ?___ Depression? ___ Skin, nail or hair dryness?__ Hair lost? ___ Skin tingling & burning?__ Acne ? ___ Skin rashes ?___Eyes red &/or blurred ?__ Dental or gum problem?__ Canker sore?___ Heartburn ?___ Headaches ?___ Frequent urination? ___ Decrease in sexual desire? ____ Fear of colon cancer?__ Fear of breast cancer? __ Fear of heart disease?___ Fear of stroke? ___Fear of getting osteoporosis?

Allergies

Please indicate any known allergies to medications, foods, and other agents, and types of reactions._____

Digestion

Do you have any problems with digestion?------- if yes, please describe_____
How often do you move your bowels?_____ describe the color, consistency, and odor of the stool? _____
Do you have any problems with swallowing, indigestion, heartburn, abdominal bloating, ma digestion, irregular bowel movements, loose or constipation, intestinal candidacies or parasites?_____

Moods and emotions

Do you tend to be even/stable in your moods or variable? _____
If variable, is this a problem for you? In what way? What contributes to it or affects it?

Are you a" the glass is half full" or "the glass is half empty" type of person?
Are you easily irritable or impatient?
Do you have any practices for managing your moods?___ What are they? ___

Sleep*:*

do you have trouble falling asleep?_____ How well do you sleep?
Do you awake at night?_____ if yes what time? _____ and do you eat at night?___
Do you wake up fresh?___ or Tired?_____ Do your legs or arms jump and awake you?

Have you ever experienced symptoms of PMS? Yes_____ No _____
If so, what symptoms?_____ what age when your period started?_

_____

YOUR SPIRITUAL /BELIEFS/FEARS/INTUITION SYSTEM?

Stress /Body and Mind

Please mark the level of your happiness and stress
Rate stress on a scale of 0(not stressful) to 10(very stressful) with Job___
and or lifestyle __
Rate happiness on a scale of 0 (not happy) to 10 (very happy) with Job___
and/or lifestyle __
Indicate the main sources of tress. In your assessment, to what extent does stress contributes to your health problems?

YOUR FUTURE LIFESTYLE

*What is your overall evaluation of your **energy** and health?_____*

6am 8am 10am 12noon 2pm 4pm 6pm 8pm 10pm 12mn 2am 4am

What factor known to you which affect your energy level?_____
What is your favorite time of the day? ___ what happens?_____
What is your least favorite time of the day? What happens?_____

Do you smoke or have you smoked in the past? Yes____ No_____
If yes, for how long?_____ How many cigarettes per day?_____
If stopped, when did you stop?_____

Do you drink alcohol? Yes____ No_____
If yes, less than 2 drinks per day?____ more than 2 drinks per day_____

Do you exercise regularly?
If yes, for how long_____ how frequently? _____ Yes____ No____
what type?_____ how strenuously? _____

Do you practice meditation? Yes___ No_____
If yes, for how long____ how frequently? _____what type?_____

YOUR HEALING GOALS

Do you take vitamins, minerals, enzyme or other supplements? Yes____ No____
If yes, please list_____

Do you take herbs? If so, please indicate their name and reason for taking
_____

_____

Are you allergic to any foods?____ Please list _____
Any food that you can not tolerate or digest?_____ Please list_____
_____

Do you consider your diet good____ avg___ poor____
Describe why you have so classified your diet?_____
_____

Do you regularly skip any meals? No___Yes ___if yes, which ones?____
Do you snack during the day? No___ Yes ____ if yes, what time (s) of day?

How frequently do you consume below foods?
Please check the following:
for daily (D) for 2 times per week (W) for often (O) for never (N)
milk ___ cheese_____ yogurt_____ red meat_____ poultry____
fish_____ eggs_____ legumes/beans_____ tofu___nuts/seeds_____
grains___rice____pasta____ fruits ____vegetables____ greens/ herbs _____
Any additional comments you would like to offer?

CONSTITUTIONAL EVALUATION

The fixed attributes such as body frame, weight and complexion, plus the state of metabolism and digestion gives us a good indicator of your prakruti. Life long habits and proclivities are also good indicators as well. If you feel that two statements in some of the categories fit you then mark them both down

JOINTS:
--- dry, popping sounds, cracking
--- medium, soft, loose, may have inflammations
--- well built joints, thick

LEGS:
--- may be excessively long or short, bony knees, thin
--- medium sized legs, medium strength
--- large, well built, stocky

NAILS:
--- thin, brittle, dry, cracked,
___ bite the nails
____soft, pink, well formed
____ smooth, firm, large, white, oily

URINE:
--- scanty, colorless
--- profuse, yellow or may have blood in it, may be dark yellow, brown or burning
--- moderate, may be milky white in color

FECES:
--- dry, hard, difficult, gas, scanty amount of feces, may have tendency to constipation, irregularity
--- loose, may have abundant amount and yellowish, not formed with burning sensations
--- moderate amount, solid, formed, may have mucus in stool

APPETITE:
--- may be erratic, variable, may be fine one day the next day will have gas, poor digestion, and be hungry
--- strong appetite, will become irritated if does not eat on time, may have burning sensations
--- consistent appetite, slow metabolism, may eat due to emotions

CIRCULATION*:*

--- *poor, cold hands, cold feet, cold body, variable*
--- *good circulation, warm, may be too warm*
--- *slow circulation, may have cool hands but warm body*

ACTIVITY:
--- *fast, changeable, erratic, hyperactive, quick*
--- *motivated, goal oriented, intense, motivated, medium, competitive, aggressive*
--- *slow, deliberate, steady, slow*

SENSITIVITY:
--- *sensitive to wind, cold and dryness*
--- *sensitive to heat, fire, and aggravated with too much sun*
--- *sensitive to cold, damp, foggy area, likes sun*

SLEEP:
--- *light, may suffer from insomnia, worries when wakes up at night*
--- *moderate, if wakes up goes back to sleep easily*
--- *heavy, sleeps deeply but may be groggy when wakes up*

RESISTANCE:
--- *may have weak immune system, variable resistance*
--- *medium resistance, may get infections, heat, inflammatory conditions*
--- *good resistance, generally strong immunity*

Email completed questionnaire to Dr. Sonia at:

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or Mail to:

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