Christina Melancon, CPT, CPI, CNC, CFTS, CDS II
*"Inspiring Vitality & Youthfulness."*

Date:_____

Name: _____

DOB:_____

Address: _____

_____

Cell phone (or preferred number): _____

E-mail: _____

Reason for scheduling appointment (main concerns):

1._____

_____

2._____

_____

3._____

_____

Are you currently taking any nutritional supplements, vitamins/minerals? Please list them:

_____

_____

_____

_____

Do you follow an exercise program, if so please describe type and frequency per week:

_____

_____

Briefly explain your daily schedule (food, activity, and sleep):

| | |
|---|---|
| 5a | |
| 6a | |
| 7a | |
| 8a | |
| 9a | |
| 10a | |
| 11a | |
| 12p | |
| 1p | |
| 2p | |
| 3p | |
| 4p | |
| 5p | |
| 6p | |
| 7p | |
| 8p | |
| 9p | |
| 10p | |
| 11p | |
| 12p | |

| | |
|---|---|
| ***Medications*** *- Please list any prescribed medications that you are presently taking:* | |

| MEDICATION NAME | REASON FOR TAKING |
|---|---|
| *1.)* | |
| *2.)* | |
| *3.)* | |
| *4.)* | |
| *5.)* | |
| *6.)* | |
| *7.)* | |
| *8.)* | |

| Surgeries - Please list any past surgeries you have had (*e.g. tonsils removed, hysterectomies, open heart surgery, etc.):* | DATE OF SURGERY | |
|---|---|---|
| *1.)* | *mm: ___* | *yyyy: ___* |
| *2.)* | *mm: ___* | *yyyy: ___* |
| *3.)* | *mm: ___* | *yyyy: ___* |
| *4.)* | *mm: ___* | *yyyy: ___* |
| *5.)* | *mm: ___* | *yyyy: ___* |

*Allergies – Please list anything that you are allergic to:* ALLERGIES

| 1. Alcohol YES/NO | 6. |
|---|---|
| 2. | 7 |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

| Do you have dental amalgam (mercury) fillings? | *Yes*: | *No:* |
|---|---|---|
| If yes, how many? | *In the past*: _____ | *Currently*: _____ |
| GENETIC HEALTH HISTORY | | |
| Mother: | | |
| Father: | | |
| (Maternal) Grandfather: | | |
| (Maternal) Grandmother: | | |
| (Fraternal) Grandfather: | | |
| (Fraternal) Grandmother: | | |
| Sister: | | |
| Sister: | | |
| Brother: | | |

At Ivy Vitality, we approach health and well-being from a holistic perspective. We believe there are metaphysical reasons for physical ailments. Have you had or are you experiencing any emotional trauma(s) that you would like to share with your practitioner? (This may include physical, sexual, mental, or spiritual abuse. This may include death of a close friend or family member, divorce, financial hardship,

toxic relationships, or other events you feel have been traumatic for you).

| EVENT | WHEN OCCURRED | HOW DO YOU FEEL |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you have any unexplained physical pain (that was not the result of an injury) in any part of your body? Example: Knee pain, shoulder pain, back pain etc. If so, please list here:

_____

## AIR

Check what currently applies to you

___I am always indoors ___Do not regularly change home air filter

___Home has mold ___Home has an air ionizer ___Have plenty of green plants in my living space

___Practice deep breathing exercises regularly, especially outdoors

___I live away from city smog ___Dizziness ___Headaches ___Watery eyes ___Sneezing

___Cough regularly ___Fatigue ___Smoke cigarettes regularly

## WATER

Check which currently apply

___Dry mouth, dry eyes, dry nasal membranes ___Dry or leathery skin ___Dry or chapped lips

___Stools hard & Dry ___Low volume of urine, urinate infrequently

___Dark urine (dark yellow or orange) ___Poor skin turgor (loss of elasticity of skin) ___Headaches

___Leg and arm cramps ___Weakness ___Drink less than eight 8 ounces glasses of water daily

## EMF

Check what you are presently experiencing

___Headaches ___Nausea ___Brain fog ___Sleep disorders ___Loss of memory

___Sensitive skin ___Dizziness ___Burning sensation ___Rash

___Vision problems ___Chest pains ___Swollen lymph nodes

___Live near electrical towers ___Teeth & jaw pain

___Constantly having cell phone to the ears ___On computer more than six hours

___Aching muscles ___Fatigue ___Bouts of unexplained fear or anxiety

___Tingling or prickly sensation across face or other parts of body

___Feeling of impeding influenza but never quite breaks out

## FIBER

Check which presently applies to you

___Painful or hard bowel movements ___Constipated, less than 1 bowel movement a day

___Varicose veins ___hemorrhoids or rectal fissures ___Use lots of toilet paper to clean yourself

___Stools are pencil size and drop to the bottom of the toilet.

## DIET

Check what currently applies to you

___Consume six types of vegetables daily ___Eat at least two types of fruit daily

___Consume at least an ounce of raw nuts daily

___50% of my diet is made up of raw foods

___I do not consume dairy, wheat or gluten containing foods

___I consume very little dairy or gluten (2 to 3 meals a week)

___Eat fresh and/or organic foods as much as possible ___Vegetarian ___Vegan

___Eat white fish two to three times a week

How often do you consume the following foods?

Answer: daily/weekly/more than once a week

Fried foods_____ Fatty meats/lunch meats_____

Soft drinks_____ Candy or gum _____

Commercial pizza_____ Pork meat_____

Bottom dwelling fish (shrimp, lobster, clams, etc._____

Refined white flour products (bread, rice, pasta, etc.)_____

Commercial Cookies/desserts_____ Margarine_____

## Toxic Survey

- Check which currently applies
- Section A: General toxicity
- ___Allergies ___Chronic Headaches/migraines ___Chronic skin problems
- ___Digestive problems ___Diabetes ___Auto immune disease ___Difficulty sleeping
- ___Depression/poor mood ___Low energy ___Liver dysfunction ___Overweight
- ___Sore muscles or stiff joints ___Unhealthy cravings
- ___Chemical sensitivities/Environmental illness ___Sleepy after meals
- ___Food allergies/food intolerance

How much alcohol do you drink per week?

___I am a recovering alcoholic ___History of drug or alcohol abuse ___History of Hepatitis

___Long term use of prescription or recreational drugs ___Sensitive to chemicals

___Sensitive to tobacco smoke ___Pain under right side of rib cage

___Hemorrhoids or varicose veins ___Chronic fatigue or fibromyalgia

___Nutrasweet consumption ___Sensitive to Nutrasweet (aspartame)

Adrenal

Check which presently or frequently occurs

___Tend to be a night person ___Difficulty falling asleep ___Slow starter in the morning

___Keyed up, trouble calming down ___Blood pressure above 120/80

___Headache after exercising ___Feeling wired or jittery after drinking coffee

___Clench or grind teeth ___Calm on the outside, trouble on the inside

___Chronic low back pain, worse with fatigue ___Become dizzy when standing up suddenly

___Difficulty maintaining manipulative correction ___Pain after manipulative correction

___Arthritic tendencies ___Crave salty foods___Salt foods before tasting

___Perspire easily ___Chronic fatigue or get drowsy often ___Afternoon yawning

___After headaches ___Asthma, wheezing or difficulty breathing

___Pain on the medial or inner side of the knee ___Tendency to sprain ankles or shin splints

___Tendency to need sunglasses ___Allergies and/or hives ___Weakness, dizziness

Thyroid

Check which presently or frequently you experience

___Sensitive/allergic to iodine

___Difficulty gaining weight, even with large appetite

___Nervous, emotional, can't work under pressure ___Inward trembling

___Flush easily ___Fast pulse at rest ___Intolerant to high temperatures ___Difficulty losing weight

___Mentally sluggish, reduced initiative ___Easily fatigued, sleepy during the day

___Sensitive to cold, poor circulation (cold hands and feet) ___Chronic constipation

___Excessive hair loss and/or coarse hair ___Morning headaches, wear off during the day

___Seasonal sadness ___Loss of lateral 1/3 of eyebrow

## Men Only

Check which presently or frequently applies

___Prostate problems ___Difficulty with urination or dribbling

___Difficult to start or stop urine stream ___Pain or burning with urination

___Waking to urinate at night ___Interruption of stream during urination

___Pain on inside of legs or heels ___Feeling of incomplete bowel evacuation

___Decreased sexual function

## Women Only

Check which presently or frequently applies

___Depression during periods ___Mood swings associated with periods (PMS)

___Crave chocolate around period ___Breast tenderness associated with cycle

___Excessive menstrual flow ___Scanty blood flow during periods

___Occasional skipped periods ___Variations in menstrual cycle ___Endometriosis

___Uterine fibroids ___Breast fibroids, benign masses ___Painful intercourse ___Vaginal discharge

___Vaginal itchiness ___Vaginal dryness ___Weight gain around hips, thighs and buttocks

___Excessive facial or body hair ___Thinning skin ___Hotflashes

___Night sweats (in menopausal women)

## Kidney and Bladder

Check which presently or frequently occurs

___Pain in mid-back region ___Puffy around the eyes, dark circles under eyes

___History of kidney stones ___Cloudy, bloody or darkened urine

___Urine has a strong odor

## Immune System

Check which presently or frequently occurs

___Runny or drippy nose ___Catch colds at the beginning of winter ___Adult acne ___Itchy skin

___Cysts, boils, rashes ___History of Epstein Bar ___Frequent colds or flu ___Frequent infections

___Mucous producing cough ___History of Mono, Herpes

___History of Shingles, Chronic fatigue, Hepatitis or other chronic viral condition

What are YOU willing to do to feel better, live longer, and be happier?
What are the top 5 habits you can you commit to right now?

1. Take all-natural, herbal supplements
2. Get better quality sleep
3. Exercise regularly
4. Improve personal relationships (identify and avoid toxic relationships)
5. Attend mental health therapy (if needed)
6. Take time out for a creative hobby
7. Drink more water
8. Discover nature therapy (make time to be in nature- twice per week)
9. Daily meditation (20 minutes plus)
10. Holistic health modalities as recommended (massage therapy, PEMF, Rife, etc)
11. Spiritual health (seeking a higher source, prayer and education)
12. Quit destructive habits
13. Journaling
14. Improve diet (eat more fiber, fresh fruits and vegetables)
15. Positive self-talk (redirecting the negative voice in your head)

What are your health and wellness goals?

_____
_____
_____