Healthy Action Planning Form
"Feel Like You Again" 6 weeks Masterclass

PERONAL DATA

Surname: ____________________________ First name: _______________ Preferred name/nickname: ____________

Address: ____ City: _______________ Province: ____ P/C: _________

Phone: Home – (____) _____-_________ Cell – (___) _____ - _____________ Where can we leave a message? H / C

Email:___________________________________ Date of Birth: (mm/dd/yyyy) ____________ Age: _____ Sex: F / M

How did you hear about our online program? ____

CHIEF HEALTH CONCERNS

Main health concern For how long have you had this problem?

1.____ ______________________________

Please describe further

Second main health concern For how long have you had this problem?

1.____ ______________________________

Please describe further

Third main health concern For how long have you had this problem?

1.____ ______________________________

Please describe further

HEALTH STATUS

Current weight: _______________ Ideal Weight: ____________ Maximum Weight: _________ When: __________

What do you usually eat and drink for:
Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

MEDICATIONS / SUPPLEMENTS: (if you need more space, feel free to attach a separate page)

Any medications/supplements that you have taken or are currently taking. (P = past / C = current)

Starting Age	P/C	Medication/Supplement	Illness	Adverse Reactions

MENSTRUAL HISTORY:
Are you still menstruating? Yes No Date of your Last menstrual period: ______________________
Do you have regular periods? Yes no Please explain ______________________________
Are you taking a birth control pill or use an IUD? Yes No Which one? ______________________
Are your periods heavy? Yes No Are you pregnant? Yes No
How many times do you change pads / tampons / menstrual cup per day? __________
Do you suffer from PMS (pre-menstrual syndrome)? Yes No What symptoms: __________________

Are you in menopause? Yes No Approximate date of your last menstrual period: _______________
Did you have a hysterectomy? Yes No When? _______________ Reason: ___________________
Do you still have your ovaries? Yes No

ENERGY:
On a scale of 1 to 10 (1 being the lowest), rate your: Energy Level __________ Stress Level _______

SLEEP: Do you sleep well? ☐ Yes ☐ No How many hours do you sleep per night? __________

EXERCISE
Frequency: ☐ None ☐ 1 - 2 days per week ☐ 3 - 4 days per week ☐ 5 - 7 days per week
Type: ☐ Walk ☐ Run / Jog / Jump Rope ☐ Swim ☐ Weight Lift ☐ Other ______________

HEALTH HABITS:
☐ Alcohol: Wine_____ glasses / day or wk, Liquor_____ oz / day or wk, Beer_____ glasses / day or wk
☐ Caffeine: Coffee _____ cups / day, Tea _____ cups / day, Soda _____ cans/bottles / day
☐ Water _____ glasses / day ☐ Cow's Milk _____ glasses / day ☐ Herbal Tea _____ cups / day
☐ Tobacco: Cigarettes _____ / day, Cigars _____ / day, Date Started ________________
☐ Recreational Drugs: Which one:__________________ Frequency: __________ per day or wk or month

NUTRITION:
☐ Skip breakfast Number of meals per day _________ Food restrictions ______________________
☐ Graze (small frequent meals) ☐ Eat constantly (whether hungry or not) ☐ Generally eat on the run

PAST/CURRENT MEDICAL HISTORY: Write on the left side a "P" for PAST or a "C" for Current to anyone that applies:

	Fatigue / low energy		Arthritis		Irregular Periods		Skin problems
	Cancer: Breast		Heart disease / Stroke		PMS (premenstrual synd)		Hypothyroidism
	Cancer: Ovarian		High cholesterol		Heavy/ Painful Periods		Hyperthyroidism
	Cancer: Uterine		High blood pressure		Endometriosis		Hot flashes
	Cancer: Prostate		Low blood pressure		Ovarian cysts		Night sweats
	Depression / Anxiety		Hypoglycemia		Cystic Breasts		Hormones Use
	Diabetes Type 1 or 2		Yeast/Bladder Infections		Hysterectomy		Allergies
	Osteoporosis		Overweight / Obesity		Infertility		Recurrent colds & flus
	Bloating & gassiness		Headaches / migraines		Miscarriages		Autoimmune problems
	Constipation/ Diarrhea		Mood swings		Low Sex drive		Other________________
	Heartburn / GERD		Irritability / Rage		Birth Control Pill or IUD		Other ________________
	Fibroids		Hair Loss		Problems with memory		Other ________________

I would like to make sure you get the most out of our 6 weeks together. What would you like to achieve?

____

____

____

____

____

____

____

____

1. I authorize and consent to the information that I will receive from Sandra Miranda ND of my own free will and choice.
2. I understand that I am at liberty to seek or continue medical care from a physician or health care provider.

_____________________________   _____________________________

Patient's Signature   Date

MIRANDA NATUROPATHIC CLINIC
10-467 Westney Rd South, Unit 10, Ajax, ON, L1S 6V8
905-239-3900 info@mynaturalclinic.com www.mynaturalclinic.com