



Nature Care College

NATUROPATHY NUTRITION HERBAL MEDICINE CLIENT CASE TAKING FORM

Client name: _____ **DOB:** _____
Student Name: _____ **Student #:** _____
Clinic Supervisor: _____ **Date:** _____

Clinic Attending: Naturopathy ☐ Nutrition ☐ Herbal Medicine ☐

PRESENTING SYMPTOMS

(P++/sensation, location, duration, what was happening when presenting symptoms began, better by/worse by, current treatment etc.)

PAST HISTORY (Vaccinations, childhood illness, accidents etc)

FAMILY HISTORY (CVD, cancer, bowels, diabetes, liver disease)

Please note if history is on mother's or father's side, siblings etc.

SLEEP (How many hours per night, any problems, dreams, wake refreshed?)

ENERGY (0-10, any slumps, what time?)

ALLERGIES / INTOLERANCES (foods, alcohol, drugs, environmental)

What is the reaction like?

MEDICATIONS & SUPPLEMENTS:

LIFESTYLE

(Exercise, relaxation, job satisfaction, anxiety, depression, mood swings?)

DIET

BREAKFAST	
Morning snack	
LUNCH	
Afternoon snack	
DINNER/DESSERT	

Water: _____

Tea/Coffee: _____

Alcohol (How does it affect you?): _____

Cravings/Aversions: _____

How often do you eat out or get takeaway meals? Any specific preferences?

What happens if you skip a meal?:

What is your energy like after a meal?

Do you eat when under stress / emotional eating (what type of food)?

When cooking do you use fresh, canned, frozen and packaged foods?

BOWELS

How often?; Do they feel 'empty' afterwards?; What do they look like/colour?; Is there any blood or mucous

PHYSICAL EXAMINATION

(Observations: dandruff, hair, dark circles, skin, walking, sitting, tremors, smell?)

Nails: _____

Eyes: (Glasses/contacts, glare, night vision, swollen, infections, black shadows)

Ears: (hearing too acute, waxy, noises, infections)

Tongue:

Blood Pressure: _____

Pulse: _____

IRIS

Colour: _____

ANW: _____

Texture: _____

Lesions: _____

GIT: _____

Lymph: _____

TREATMENT PROGRAMME

STUDENT'S SUMMARY