

# LIVING TRANSFORMED – HEALTH COACHING 2020

## What should I expect during my visit?

Welcome to your first consultation! I'm excited to be helping you through your path to health and healing. For most accustomed to the atmosphere of a traditional doctor's visit I want to prepare you for the differences that lie ahead.

For many a Naturopath is just a confusing synonym for *alternative medicine*. However, historically speaking naturopathy existed long before what we commonly know as traditional medicine. Hippocrates "the father of modern medicine" was a naturopath that taught his basic law of medicine, "***Above ALL, Do No Harm***".

The fundamental belief in naturopathy is that the body was **created** with an innate ability to heal itself. Contrary to the traditional medical paradigm, naturopaths are trained to recognize, support, and enhance this God-given ability. We believe that symptoms are an indication of our body's attempt to heal and repair itself. It is understandable to want relief from symptoms and ongoing discomfort, but in doing so we should refrain from robbing our bodies of the ability to naturally fight-off illness while also being careful not to sustain any collateral damage. When our symptoms become chronic the body is overwhelmed and in need of external assistance. The naturopaths' focus will then be to understand what your symptoms are an indication of, how long they have been a problem, and ultimately identify what is obstructing the healing process.

At the core of naturopathy the root cause of disease is **toxicity** and **deficiency**. **Toxicity** is an overabundance or accumulation of harmful matter (i.e. digestive and cellular waste, parasites, heavy metals, yeast, viruses, bacteria, environmental pollution, as well as negative emotions) throughout any organ or system of the body.

Two time Nobel Prize winner Linus Pauling categorically stated to the 74<sup>th</sup> Congress of the U.S. "*Every ailment, every sickness, and every disease can be traced back to an Organic mineral deficiency*" **Deficiency** is a lack of the vital substances (i.e. vitamins, minerals, amino acids, enzymes, antioxidants, water, proteins, fats, and carbohydrates) required for optimal bodily functions. Throughout the course of your visits with I will be recommending various lifestyle changes as well as supplement protocols designed to fulfill your nutritional gaps.

The naturopath will also be looking to identify the areas of your life that provide toxic exposure while recommending therapies that can help detoxify and rebuild. My goal is to educate and motivate patients because **detoxification** and **significant lifestyle modification** will be the ultimate **catalyst** to your path to healing.

Naturopaths are "coaches" that encourage and guide you in the best direction. Today it's important to reflect on your overall commitment level to defeating your health challenges meeting your goals for 2019. It is my hope that you prepare your mind and heart for this exciting time of health and healing, my passion is to help reach your God-given potential and live a healthier, happier life! I look forward to meeting you.

## Notice to Clients

Darren Fink, Naturopath

This notice is provided to you pursuant of law. The practitioner above is under the scope of practice for Naturopathy, is not practicing as licensed medical doctors and therefore does not practice “the application of scientific principles to prevent, diagnose and treat physical and mental diseases, disorders, and conditions and to safeguard the life and health of any person.” A person registered to practice naturopathy or naturopathic healing under the law may counsel individuals and treat human conditions through the use of “naturally occurring substances.”

The underlying causes of disease can be improper diet, unhealthy habits and environmental factors that cause biological imbalance. A classic naturopath specializes in wellness; the teaching of natural lifestyle approaches to facilitate the body’s healing and health building potential.

I fully understand that the above name individual is not a medical doctor. This individual may counsel me on nutrition, supplements, and better health practices, but will not diagnose or prescribe remedies for disease.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient/Authorized Person Signature

\_\_\_\_\_  
Date

# Medical History

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What is the main problem that brought you in today? \_\_\_\_\_

How long have you been having symptoms? \_\_\_\_\_

**Current Medications:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Supplements:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies:**

**Drugs**

**Foods**

**Environmental (e.g. pollen)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Tested Y / N

Tested Y / N

**Past Medical History:**

Have you had any of the following medical issues?

Condition	Yes	No	Current treatment	Date Began	Date Resolved
ADD/ADHD					
Alcoholism/Drug addiction					
Allergies					
Anemia					
Anxiety					
Arthritis					
Asthma					
Autoimmune Disease Type					
Cancer Type:					
Chemical Sensitivities					
Chronic Fatigue					
Depression					
Diabetes					
Eczema					
Fibromyalgia					
GERD/reflux					
Headaches/migraines					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Condition	Yes	No	Current Treatment	Date Began	Date Resolved
Irritable Bowel Syndrome					

Lyme Disease					
Menopause					
Mental Illness					
Mononucleosis					
Obesity					
Ovarian Cysts (PCOS)					
Psoriasis					
Prostate Disease					
Recurrent Strep infections					
Thyroid Disease					
Vaginal Infections					
Other					

**Hospitalizations:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Issue:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**If female: Do you have any of the following:**

Irregular menstrual cycles?	Yes	No
Extreme heavy bleeding or cramping with menstrual cycles?		
Extremely light bleeding with cycles?		
Breast tenderness as part of PMS symptoms?		
Sugar cravings or mood swings as part of PMS symptoms?		

Have you been pregnant? Yes No If yes, ages: \_\_\_\_\_  
 If no, have you tried to get pregnant without success? Yes No  
 When was your last Menstrual Cycle? Date: \_\_\_\_\_  
 When was your last: Pap \_\_\_\_\_ Mammogram \_\_\_\_\_ Bone Density \_\_\_\_\_  
 Have you used birth control pills? Yes No If yes, how long \_\_\_\_\_

**If male: Do you have any of the following:**

Problems attaining/maintaining an erection	Yes	No
Difficulty with urination including decreased stream or increased frequency?		

**Family Medical History:**

Mother's age (at death if deceased): \_\_\_\_\_  
 Any medical conditions: \_\_\_\_\_  
 Father's age (at death if deceased): \_\_\_\_\_  
 Any medical conditons: \_\_\_\_\_  
 Siblings' ages and medical conditons: \_\_\_\_\_  
 Other family members with chronic health conditions (e.g.-diabetes, heart disease, thyroid disease):  
 \_\_\_\_\_

**Social history:**

Please circle those that apply: Single Married Divorced  
 Please circle any of the following substances that you use regularly: Tobacco / Alcohol / Coffee / Recreational Drugs

**Dental history:** Please circle those that apply: Mercury filling(s) / Tooth Abscess(es) / Root Canal(s)  
 \_\_\_\_\_

PRIMARY COMPLAINT(s): \_\_\_\_\_

Appx. date of onset: \_\_\_\_\_

Symptoms began: \_\_ Gradually: \_\_ Suddenly

### Symptom and Ailments Questionnaire #1

*Please check the appropriate box for each question.*

Symptoms – Please Circle One or all that apply on each line:	Frequently	Occasionally	Rarely	Never
Cold hands, feet, low body temperature				
Fatigue/ tiredness				
Inability to lose weight despite dieting				
Poor memory				
Poor concentration				
Constipation				
Diarrhea				
Hair loss				
Depression				
Anxiety/ nervousness				
Irregular heart beats				
Trouble sleeping				
Muscle weakness				
Muscle aches				
Joint pain				
Headaches				
Early morning stiffness				
Easy fatigue from exercising				
Sleepiness in the afternoon				
Dizzy/ lightheaded				
Sugar cravings				
Loss of voice / hoarseness				
Shaky or irritable when hungry				
Thyroid disease				
Sense of fullness during and after meals				
Belching/ burping/ bloating/ gas				
Rectal itching/ nasal itching				
Toe fungus, jock itch, or athlete’s foot				
High sensitivity to smells				
Chronic or long term hives				
Bad breath				
Sinus or breathing problems				
Easy bruising				
Slow wound healing				
Average bowel movements per day?	(1)	(2)	(3)	(4+)

## Symptom and Ailments Questionnaire #2

*Please check the appropriate box for each question.*

<b>Symptoms – Please Circle One or all that apply on each line:</b>	<b>Frequently</b>	<b>Occasionally</b>	<b>Rarely</b>	<b>Never</b>
Vaginal burning, itching or discharge				
Prostatitis or prostate cancer				
Mood swings				
Endometriosis or infertility				
Cramps or menstrual irregularities				
Attacks of anxiety or crying				
Bladder / kidney infections				
Drowsiness				
Irritability				
Eczema or psoriasis				
Itchy skin or eyes				
Chronic hives (urticaria)				
Indigestion or heartburn				
Decreased body hair				
Sensitivity to milk, wheat or foods				
Decreased sex drive				
Dry mouth or throat				
Bad breath				
White tongue				
Excessive foot, hair or body odor				
PMS pre-menstrual syndrome				
Frequent sore throats				
Laryngitis, loss of voice				
Recurring bronchitis				
Pain or tightness in the chest				
Shortness of breath				
Spots in front of eyes				
Burning or tearing eyes				
Recurring infections in eyes				
Ear pain or ringing				
Salt Cravings				
Other symptoms needing consideration:				

## Symptom and Ailments Questionnaire #3

*Please check the appropriate box for each question.*

<b>Symptoms and Ailments: Please circle one or all that apply on each line:</b>	<b>YES</b>	<b>NO</b>
Have you taken multiple courses of a broad-spectrum antibiotic drug—even in a single dose?		
Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis or other problems affecting your reproductive organs?		
Are you bothered by memory or concentration problems e.g. do you sometimes feel ‘spaced out’?		
Do you feel ‘sick all over’ yet, in spite of visits to many different physicians, no cause has been found?		
Have you been pregnant?		
Have you taken birth control pills longer than 2 years?		
Have you taken steroids orally, by injection or inhalation?		
Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke symptoms?		
Does tobacco smoke <i>really</i> bother you?		
Are your symptoms worse on damp, muggy days or in moldy places?		
Have you had athlete’s foot, ring worm, ‘jock itch’ or other chronic fungus infections of the skin or nails?		
Do you crave sugar?		
Do you have high blood pressure?		
Have you ever had angina or a heart attack?		
Have you ever had a stroke?		
Do you have diabetes?		
Do you have swelling that is not known to be the result of another health issue?		
Do you smoke?		
Do you have high cholesterol?      If yes, what is your cholesterol number? _____		
Have you ever had coronary bypass surgery?		
Is there history of heart disease in your family?		
Have you been diagnosed with sleep apnea?		

**24 hr Food Intake:**

When did you last eat? \_\_\_\_\_ hrs ago

What did you have for breakfast most commonly : \_\_\_\_\_

Lunch? : \_\_\_\_\_

Dinner?: \_\_\_\_\_

Snacks?: \_\_\_\_\_

Beverages?: \_\_\_\_\_

## Environmental Profile

According to the World Health Organization as much as 65% of all illnesses can be caused or made worse by the indoor environment. Numerous chronic diseases, which were once rare, are becoming commonplace as the levels of toxins present in our environment continue to escalate. Many times medical treatments are rendered ineffective if the environment in which a patient lives is not conducive to the healing process. During the course of your medical treatment the physician obtains a complete profile of your living environment. This will enable Progressive Medical Centers of America to determine if your illness is caused or worsened by your living or working environment and to specifically individualize a treatment program for optimal results.

***Please circle one or all that apply on each line and answer the following questions by checking YES or NO:***

Question	Yes	No
Are pesticides in your home or office?		
Do you use natural cleaning and laundry products?		
Is the construction of your house less than 15 years old?		
Have you had plumbing leakage, wet carpets or other water damage anywhere in your home?		
Do you have animals live indoors?		
Do you or your neighbors use lawn chemicals?		
Do you have moldy odors, mildew or visible molds anywhere in your home?		
When turning on your heating or air conditioning system(s) do you smell foul or moldy odors?		
Does the dust in your home reappear shortly after dusting?		
Do you have "blown-in" insulation in your attic?		
Are you, or is anyone in your home, experiencing any chronic ailments such as asthma, allergies, sinus infections, respiratory problems, or frequent cold or flu-like symptoms?		
Have you ever had bird, rat, mouse or any rodent infestation in your home?		
Do you have a "crawl space" or an unfinished basement in your home?		
Do you feel better after you leave your home or office for an extended period of time?		
Do you use only natural products for your skin?		
Do you have moldy odors or visible molds in your workplace?		
Has there ever been water stains on the ceiling tiles, chemical odors, dirty air vents or excessive dust intrusion in your home or workplace?		
Do you frequently feel tired or run-down at the end of a workday?		
Do your family members and co-workers frequently complain of headaches, colds or flu-like symptoms?		
Is smoking permitted in your workplace or home?		
Do you have carpeting in your home or office?		
Do you use a filter for all drinking, cooking and shower/bath water?		
Do you have an air filter in your home or work place?		

What is your current occupation? \_\_\_\_\_

If less than one year, what was your prior occupation? \_\_\_\_\_