Please answer briefly the below questions. Mark N/A if not relevant to you.
Thank you!

AGE:

PROFESSION/CAREER:

EDUCATION LEVEL:

MARRIED STATUS/SATISFACTION:

CURRENT MEDICATIONS:

HEREDITARY DISEASES:
DIAGNOSED HEALTH CONDITIONS/ILLNESSES:

NUMBER OF STOOLS/DAY:

CAREER SATISFACTION:

EMOTIONAL ABUSE:

FAMILY/SOCIAL LIFE:

SPIRITUAL LIFE:

LIFE IS PURPOSEFUL?

ENERGY LEVEL:

MENSTRUAL CYCLE PROBLEMS:

REASON FOR PROGRAM/CONSULTATION:

EXISTING LIFESTYLE:

EATING/DIET HABITS (any food allergies?)
SLEEPING PATTERN:

HOBBIES:
GOOD HABITS AND RELAXATION EFFORTS:

NEGATIVE HABITS/ADDICTIONS:

EMOTIONS TO REDUCE:

BREATHING HABITS: