



**Lotus Wellness Cottage**  
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## Health Profile

Name \_\_\_\_\_

Date of Birth (DOB) \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Place of Birth \_\_\_\_\_

If Child, Parent Name: \_\_\_\_\_ Parent DOB: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone (home) \_\_\_\_\_ (other) \_\_\_\_\_

Email: \_\_\_\_\_

Skype Username (if applicable): \_\_\_\_\_ Time Zone: \_\_\_\_\_

How did you hear about us? Who referred you? \_\_\_\_\_

\_\_\_\_\_

### Living / Household Arrangements:

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Cohabiting \_\_\_\_\_

Live with: Spouse \_\_\_\_\_ Parents \_\_\_\_\_ Relatives \_\_\_\_\_ Friends \_\_\_\_\_ Alone \_\_\_\_\_ Other \_\_\_\_\_

Pets (list) \_\_\_\_\_

What type of education do you have? \_\_\_\_\_

What profession or type of work do you do? \_\_\_\_\_

Occupation \_\_\_\_\_ Full or Part Time \_\_\_\_\_ Retired \_\_\_\_\_

**Military Service:** Where did you serve? \_\_\_\_\_

When did you serve? \_\_\_\_\_

Did you get injuries, vaccinations or treatments of any kind? \_\_\_\_\_

\_\_\_\_\_

Are you familiar with, or have you ever had Homeopathic or Naturopathic Therapies?

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**YOUR CHIEF COMPLAINTS:**

In your opinion, what are your most important health problems? List as many as you can in order of severity:

1) _____	4) _____
2) _____	5) _____
3) _____	6) _____

Comments about your most important health problems:

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To analyze your case, very specific information is needed to come up with homeopathic remedies, herbal tinctures and other things to support you. Please take the time to fill this out and return it as soon as you can.

**Health Issues & Background:**

Please list any health issues you would like to work on - For each issue include when it began, what was going on in your life at that time (include emotional events that impacted you) and any other details you feel are important.

- Have you had any health conditions (physical or emotional), as well as surgeries in the past? Please detail.
- Have you had any previous reactions to vaccinations or drugs? Please explain and list exact drug or vaccination.

**Mental/Emotional State:**

- How do you feel emotionally on a day to day basis? Please detail and include any information on prior events that may have impacted you being in this current state.
- Do you have any physical symptoms with this emotional state? Please detail.

**Head Injury:**

- Did you ever have a head injury, concussion or been knocked unconscious? Explain with date.
- Any results / issues that remain since this injury? Include emotional.

**Sleep:**

- Do you have trouble falling asleep or staying asleep?
- If you wake in the middle of the night, what time do you wake up?
- When you cannot sleep what is going through your mind?

**Medications, Vitamins, Remedies:**

- Are you sensitive to medications, remedies, etc.? Are you a sensitive person in general?
- List vitamins, supplements, herbs, as well as any prescription and non-prescription medications you are currently taking. Include the reason you are taking them.
- Do you use any type of recreational drugs? Include what type and how often.
- What homeopathic remedies were previously taken or currently taking and results from each?

**Foods and Eating:**

- What type of foods do you crave or gravitate to? (Not what you should eat or make yourself eat, but what you would like to eat if you could eat anything.)
- What type of drinks do you like to drink?
- Are you a thirsty person (liquids), moderately thirsty or are you rarely thirsty?
- Do you want ice in your drinks?

**Bowels/Kidneys:**

- Do you get diarrhea or are you constipated? Please explain.
- Any difficulties with urinating/ your kidneys? Please explain.

**About You:**

- Please describe yourself briefly so I can understand your temperament, values, goals, interests, hobbies, etc. Feel free to add anything else here that you think is important or relevant including any major changes in your life.

- If you could do a general timeline of your life (birth to today) this could be very insightful and very helpful to homeopathic treatment. Try to correlate what was going on in your life around the time your physical/emotional issues began.

**Disclaimer:**

For what it's worth . . . There ARE safe alternatives to surgical, radiation and chemical methods of treatment! Natural therapies, cleansing, nourishment and other practices have been researched, taught and used for centuries to relieve stress and pain, to feel better and to live longer. Many natural health methods are NOT ACCEPTED by the American Medical Association, nor the Food and Drug Administration. Some natural healing methods are considered controversial, radical, unorthodox and even illegal. US law demands this statement: "FOR DIAGNOSIS AND TREATMENT OF DISEASE YOU MUST CONSULT A MEDICAL DOCTOR" The services performed by Judith M. Toscano, N.D., Robin Murphy, N.D. or Lotus Wellness Cottage employees are at all times restricted to the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

**Signature (parent if child is under 18)** \_\_\_\_\_

**Date** \_\_\_\_\_

**Please mail or email your completed form along with a current photo to:**

**Lotus Wellness Cottage  
104 Via Avenue  
Stuart, VA 24171  
consults@lotuswellnesscottage.com**

**Office Use Only**

<b>Appointment Date &amp; Time:</b>	
<b>Mail Chimp:</b>	
<b>Day of Week Born:</b>	
<b>Zodiac Sign:</b>	
<b>Chinese Year:</b>	