Welcome. Tell us about you.

Please complete all applicable items. You may attach additional pages or medication lists.

Full name

Today's date

Date of birth

Age

Preferred name

Street address

City

State

ZIP code

Best phone

Email

Occupation

Employer / retired

Emergency contact / relationship

Contact phone

Spouse / partner name

Phone

How did you hear about us?

Height

Number of children

Number of pregnancies

Pregnant?

- ○ Yes
- ○ No
- ○ Unsure
- ○ Not applicable

Breastfeeding?

- ○ Yes
- ○ No
- ○ Not applicable

Medical history & current concerns

Please complete all applicable items. You may attach additional pages or medication lists.

Full name **Date**

For each condition, mark P for your personal history and F for family history. Mark both if applicable.

☐ P	☐ F	Depression	☐ P	☐ F	Heart attack
☐ P	☐ F	Diabetes	☐ P	☐ F	Thyroid disease
☐ P	☐ F	Gallbladder disease	☐ P	☐ F	Kidney disease
☐ P	☐ F	Stroke	☐ P	☐ F	Fatigue
☐ P	☐ F	Brain fog	☐ P	☐ F	Hypoglycemia
☐ P	☐ F	Anemia	☐ P	☐ F	Cancer
☐ P	☐ F	High blood pressure	☐ P	☐ F	Intestinal problems
☐ P	☐ F	Shortness of breath	☐ P	☐ F	High cholesterol
☐ P	☐ F	Headache	☐ P	☐ F	Poor sleep
☐ P	☐ F	Dizziness	☐ P	☐ F	Arthritis
☐ P	☐ F	Carpal tunnel	☐ P	☐ F	Neuropathy / nerve problems
☐ P	☐ F	Weight gain	☐ P	☐ F	Back pain
☐ P	☐ F	Neck pain	☐ P	☐ F	Shoulder pain
☐ P	☐ F	Knee pain			

Main concerns (in order of importance) and how long you have had them

Are these concerns better or worse at a particular time of day?

Current medications / supplements (name, dose and frequency)

Known allergies and reactions

Lifestyle, goals & readiness

Please complete all applicable items. You may attach additional pages or medication lists.

Full name

Date

How do your concerns affect body function or quality of life?

What would be better without these concerns?

- ○ Less stress
- ○ Work
- ○ More energy
- ○ Family
- ○ Self-esteem
- ○ Outlook
- ○ Confidence
- ○ Sleep

What have you tried for weight management?

- ○ Medications
- ○ Vitamins
- ○ Exercise
- ○ Diet / nutrition
- ○ Other

How did previous methods work for you?

What barriers do you foresee? How might you address or prevent them?

What outcome would make this a success for you?

Readiness & interests

Please complete all applicable items. You may attach additional pages or medication lists.

Full name **Date**

Rate each item: 1 = lowest; 10 = highest.

Energy level

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Quality of sleep

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Importance of resolving your concerns

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Readiness to make lifestyle changes

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

I am interested in:

- ○ Weight loss
- ○ Inch loss
- ○ Healthy aging
- ○ Metabolism support
- ○ Long-term results

Wellness evaluation

Full name **Date**

Select symptoms you experience or conditions diagnosed by a practitioner. This evaluation guides discussion and does not establish a diagnosis or identify the cause of symptoms.

HEADACHES

- ○ Headaches
- ○ Migraines

HORMONAL CONCERNS

- ○ PMS
- ○ Emotional imbalance

GASTROINTESTINAL ISSUES

- ○ Abdominal bloating, cramps or painful gas
- ○ Irritable bowel syndrome
- ○ Ulcerative colitis
- ○ Crohn's / other intestinal disorders

RESPIRATORY CONDITIONS

- ○ Chronic sinusitis
- ○ Asthma
- ○ Allergies

JOINT CONCERNS

- ○ Knee, shoulder or spine

OTHER DIAGNOSED CONDITIONS

- ○ Diabetes mellitus
- ○ Lupus
- ○ Rheumatoid arthritis
- ○ Fibromyalgia
- ○ Chronic fatigue

THYROID CONDITIONS

- ○ Hashimoto's disease
- ○ Hypothyroidism
- ○ Hyperthyroidism

DEVELOPMENTAL / ATTENTION CONDITIONS

- ○ Autism
- ○ ADD / ADHD

SKIN CONDITIONS

- ○ Eczema
- ○ Skin rashes
- ○ Hives

SYMPTOM RATINGS - SELECT ONE RESPONSE PER ROW

Symptoms: 0 = none, 1 = mild, 2 = moderate, 3 = severe. Medication / antibiotic use: 0 = never, 1 = rarely, 2 = sometimes, 3 = often.

Constipation and/or diarrhea	○ 0 ○ 1 ○ 2 ○ 3		Asthma, hay fever or airborne allergies	○ 0 ○ 1 ○ 2 ○ 3	
Abdominal pain or bloating	○ 0 ○ 1 ○ 2 ○ 3		Confusion, poor memory or mood swings	○ 0 ○ 1 ○ 2 ○ 3	
Mucus or blood in stool	○ 0 ○ 1 ○ 2 ○ 3		Pain reliever use (aspirin, Tylenol, Motrin)	○ 0 ○ 1 ○ 2 ○ 3	
Joint pain / swelling or arthritis	○ 0 ○ 1 ○ 2 ○ 3		History of antibiotic use	○ 0 ○ 1 ○ 2 ○ 3	
Chronic or frequent fatigue / tiredness	○ 0 ○ 1 ○ 2 ○ 3		Alcohol consumption makes you feel sick	○ 0 ○ 1 ○ 2 ○ 3	
Food allergies / sensitivities / intolerance	○ 0 ○ 1 ○ 2 ○ 3		Gluten sensitivity or celiac disease	○ 0 ○ 1 ○ 2 ○ 3	
Sinus or nasal congestion	○ 0 ○ 1 ○ 2 ○ 3		Nausea	○ 0 ○ 1 ○ 2 ○ 3	
Chronic or frequent inflammation	○ 0 ○ 1 ○ 2 ○ 3		Weight concerns	○ 0 ○ 1 ○ 2 ○ 3	
Eczema, skin rashes or hives	○ 0 ○ 1 ○ 2 ○ 3				

Total (optional):

This total is not a diagnostic score and has no established cutoff in this form.

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