
*Albert Einstein reminded us that "You cannot correct a problem with the same thinking that created it." According to a Harvard Medical School study, approximately 70% of all cancers and chronic conditions can be prevented through lifestyle changes. Moreover, our diseases and conditions are primarily a result of stress, food, environment, attitude, emotions, and beliefs that keep us perpetuating behaviors that lead to disease. Furthermore, the Institute of Medicine indicates that ninety millions Americans are "health illiterate", which means we do not know how to interpret or use health information to control or improve our health, or prevent chronic disease. "Lack of information" was cited as the number one cause of death. Understanding that there exists a cause and effect relationship between what we know and how we behave, we need a model of integrating this important information to change the behaviors that lead to chronic disease.*

(Please answer ALL questions)

Name_____Male/Female____Date_____

Adress_____City_____St._____Zip_____

Phone (Home)_____(Work)_____(Cell)_____

Email_____Occupation_____

Date of Birth:_____/_____/_____ Height_____Weight_____

Marital Status_____ Do You Have Children, and if so how many? _____

Referral Source_____

Are you under a Doctors care? Y/ N If yes,
explain_____

Doctor's Address_____

City_____ST_____Phone_____

List any surgeries you have had _____

*What do you believe are the reasons for your present state of health?*

_____
_____
_____

*Has your health improved or worsened over the past year?*

_____

*Would you briefly describe your medical history and your family medical history mother, father, siblings)*

_____
_____
_____
_____

*Do you feel as though stress has a significant impact on your health?*

_____
_____

*Are you happy with your current energy level?*

_____

*What do you do to relax?*

_____
_____

*Have you lost or gained 10 or more pounds in the past year?*

_____
_____

*Do you generally fell well-rested?*

_____

*How many hours of sleep do you usually get?* _____

*Would you like to improve the quality or quantity of your sleep?*_____

*Would you briefly describe your upbringing and family background?*

_____
_____
_____
_____

*If you have siblings, what is your birth order in the family? (oldest, youngest, etc.)*

_____
_____

*Are you aware of any relationship patterns from your upbringing that you carry in your current relationship?*

_____
_____
_____

*Are you presently involved in a significant relationship?*

_____

*Are you presently addressing any specific emotional issues either in counseling or on your own?*

_____
_____

*What are three words that would describe who you are?*

_____
_____
_____

*Are you comfortable with who you are and where you are in your current lifestyle? What are some discomforts that you have?*

_____
_____
_____

*Is it difficult for you to clear away stress?*

_____

*Do you have a good appetite?*

_____

*Do you feel well nourished?*

_____

*Do you follow a particular diet regimen? If so, please describe?*

_____
_____

*List all medications & supplements you take regularly (including over the counter and natural herbs, tonics, or a multivitamin):*

_____
_____
_____

*List all known allergies, including food intolerances:*

_____
_____

*How many bowel movements (per day) do you usually have?*_____

*Are your Bowel Movements regular?*_____

*What is your Blood Type?*_____

*Fluids (per day in oz):*

| *Amount of Water* | *Soda* | *Caffeine* | *Alcohol* |
|---|---|---|---|
| | | | |

*What are your favorite vegetables to consume?*

_____
_____
_____

*What are your splurge foods/ or your cravings that you tend towards?*

_____
_____
_____

*Are there any foods that should be noted that irritate you or you do not digest well, or that you do not like?*

_____
_____
_____

*Please describe your living environment.*

_____
_____
_____

*Do you live alone? With a spouse/ partner? With children? Roommates? Pet?*

_____
_____
_____

*Do you think that aspects of your environment have an impact on your health?*

_____
_____

*How would you describe your everyday social and emotional environment? Which activities occupy most of your time?*

_____
_____
_____

*Where do you spend most of your waking hours?*

_____
_____

*What makes you happy / smile?*

_____
_____

*Are you presently working? If yes, what is your work environment like? What is your job description?*

*Do you exercise regularly? If so, what type of exercise and how frequently?*

*If you do not exercise regularly, would you like to? What conditions or circumstances do you think prevents you from doing so?*

*What types of exercise do you enjoy?*

*Do you breathe deeply or do you find yourself holding your breath at times?*

*Do you spend any time in nature?*

*Do you follow any type of spiritual practice, for example yoga, chanting, prayer, meditation?*

*Describe any feelings, symptoms, or problems with regard to your health that you feel should be noted:*

*What would you to receive from this appointment? Is there anything specific you would like to work on during the session? What are your goals for during this process?*

## MEDICAL

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| | | Heart Failure | | | Candida/ Yeast |
| | | Heart Disease | | | Asthma |
| | | Mitral Valve Prolapse | | | Diabetes |
| | | High Blood Pressure | | | Thyroid Disorder |
| | | High Cholesterol | | | Chemotherapy |
| | | Hemophilia | | | Arthritis |
| | | Congenital Heart Lesions | | | Metabolic Syndrome |
| | | Artifical Heart Valve | | | Multiple Sclerosis |
| | | Blood Transfusion | | | Aids / HIV positive |
| | | Heart surgery | | | Glaucoma |
| | | Artifical Joint | | | Hepatitis A (infectious) |
| | | Lupus | | | Hepatitis B |
| | | Psoriasis | | | Hepatitis C |
| | | Skin Tags | | | Liver Disease (Fatty) |
| | | Gall Stones | | | Cold Sores |
| | | Anemia | | | Epilepsy/ Seizures |
| | | Stroke | | | Depression |
| | | Kidney Stones | | | Headaches |
| | | Cancer?- Type? | | | Nausea |
| | | Tumors | | | Sleep Apnea |
| | | Drug/ Alcohol Addtiction | | | Hot Flashes |
| | | Genital Herpes | | | Joint Pain |
| | | Vertigo/ Dizzy Spells | | | Sinus Trouble |
| | | Psychiatric Treatment | | | Ears Ringing |
| | | Bruise Easily | | | Insomnia |
| | | Mononucleosis | | | Acne |
| | | Chronic Fatigue | | | Irregular Menstrual Cycle |
| | | Fibromylgia | | | Polycystic Ovaries |
| | | Cold Hands & or Feet | | | Abnormal Blood Work |

## Intestinal Conditions

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| | | | | | |
| | | Black Stools | | | Anal / Rectal Itching or burning |
| | | Bloating | | | Hungry After Eating |
| | | Celiac Disease | | | Rectal Bleeding |
| | | Colon Cancer | | | Hemorroids |
| | | Constipation | | | Mucus in Stool |
| | | Colonics | | | Ulcers |
| | | Diarrhea | | | Chrone's Disease |
| | | Hard Stools | | | Irritable Bowel |
| | | Reflux/ Heartburn | | | Fatigue After Eating |
| | | Fissure | | | Lactose Intolerance |
| | | Fistula | | | Parasites |
| | | Diverticulitis/ osis | | | Gastric Bypass |

## Drugs

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| | | Marijuana | | | Barbiturates |
| | | cocaine | | | Sedatives |
| | | heroine | | | Hormone Therapy |
| | | nicotine | | | Steroids |
| | | Methamphetamines | | | Birth Control Pills |

Do you have any disease, condition, or problem not listed?

_____

_____

**Disclaimer**:

The nutritional and health information given to you by the whole health consultant during any appointment or consultation, whether on the phone or in the office, newsletters or handouts is based on the consultant's personal experience and research. It is intended to help you make informed decisions regarding the state of your health and how your lifestyle choices affect your wellness. Due to the fact that there is always the risk of unforeseen results when changing your diet or lifestyle, please do not apply this information unless you are willing to assume any risks. If you choose to use diet and lifestyle changes as a form of treatment for any illness or disease without the approval of a medical physician, you are, in effect, prescribing this for yourself, which is your right. If you are ever in doubt about the appropriateness of a treatment for yourself, please consult a physician prior to receiving Whole Health Consulting or Nutritional Counseling.

**Cancellation Policy**:

We understand that circumstances can and do occasionally arise which would make you unable to attend a scheduled appointment. To prevent any late charges, our policy requires that you give us 24 hour notice of any cancellation at which time, we would be happy to reschedule your appointment. We feel this is the fairest policy for all concerned, and appreciate your cooperation in this matter.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally and individually responsible for payment at the time of service. I hereby approve that the therapist or health consultant will not be held responsible for any medically diagnosed conditions, and I understand that the health consultant does not diagnose or prescribe. The information being given is true and accurate to the best of my knowledge.

Client Name (Print)_____

Signature_____Date_____