| Date: | Natural Wellness Center - CONFIDENTIAL | QB: □ Log □ Scan: □ BD: □ | Referred By: |
|---|---|---|---|

Name: _____ Sex: M / F Date of Birth: _____ Age:_____

Phone: *Home*: _____

Address: _____

*Work*: _____

City: _____ Zip:_____

*Cell*: _____

How did you hear about us?_____ Email:_____

**Is this a Full Comprehensive Consultation (fees apply) or a 10 minute Complimentary Consult?** ***Full Consult Complimentary Consult***

**What are your reasons for coming in today? Main Health Concerns and Health Goals (Please List)?**

**1.** _____ **2.** _____ **3.** _____

**Put a check next to your daily habits:**

- ❑ Skip meals
- ❑ Eat too much/too fast
- ❑ Addicted to carbs
- ❑ Eat junk food/fast food
- ❑ Eat out # wk_____
- ❑ Emotional eating
- ❑ Drink alcohol #_____
- ❑ Drug Use/Recreational Drugs
- ❑ Constant Snacking
- ❑ Smoke/Past Smoker #_____
- ❑ Strong cravings (sweet/salt/fat)
- ❑ Not enough water #_____
- ❑ Energy: 1 2 3 4 5(best)
- ❑ Caffeine Intake:_____
- ❑ Sleep Hours/Day:_____
- ❑ Exercise/Week:_____
- ❑ T.V hours/Day_____
- ❑ Daily Stress: 1 2 3 4 5(high)

**Do you have any health issues?**

- ❑ High Cholesterol
- ❑ High Blood pressure
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Arthritis
- ❑ Joint Problems
- ❑ Menopause/Hormonal Imbalance
- ❑ Thyroid
- ❑ Weight Problem-Over/Under Weight
- ❑ Cold/Flu/Immune System
- ❑ Migraines/Head Aches
- ❑ Digestive Problems
- ❑ Gas/Bloating
- ❑ Constipation or Diarrhea
- ❑ Asthma
- ❑ Mental Illness/Health
- ❑ Cancer
- ❑ Osteoporosis
- ❑ Other_____
- ❑ Allergies/Sensitivities_____
- ❑ Meds/Supplements_____

**Diet/Food List (list foods you eat for each meal)** Are you vegetarian: Yes / No Blood Type:_____

Breakfast: Lunch: Dinner: Snacks: Drinks:

What is your motivation for your overall health and well-being?

What are you looking for with your health, a quick fix, or looking for optimal health and wellness?

- ❑ Short term goal, Quick Fix
- ❑ Prescription for Life, Optimal Health

Are you ready to follow a structured program? (circle) Yes / No

**FAMILY HISTORY** (List any known health problems of family members.)

**PAST MEDICAL HISTORY** (list any past hospitalizations, surgeries, illnesses, immunizations)

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a copy of the Notice from your receptionist. I hereby acknowledge that I reviewed from the Natural Wellness Center a copy of the Notice.

**CONSENT FOR CONSULTATION**

I, the undersigned, hereby authorize Natural Wellness Center (NWC), (and/or any associate or assistant involved in my care) to treat my condition(s), and fully understand that there is no promise or stated guarantee has been made as to result or cure; and I will not hold NWC and its staff responsible for my individual results of services that I have requested. I certify that the information I have reported with regard to my confidential patient fact sheet. **If patient is a minor**, unable to sign or incompetent to give consent, relationship of person authorized to give consent must be noted.

Print Your Name | Your Signature | Date

---

Name of Parent or Guardian | Your Signature | Relationship | Date