



True Wellness

Client Information

Name _____ What do you prefer to be called? _____

Date of Birth ____/____/____ Sex M__F__ Today's Date _____

Address _____ City _____

State _____ Zip _____ email _____

Home Phone _____ Cell _____

Occupation _____ How Long _____

Marital Status (Circle One) Single Married Separated Divorced Widowed Spouse's Name _____

Please explain the reason for your visit today: _____

Circle all the different types of practitioners you have been to in the past:
Nutritional Consultant Homeopathic Consultant Naturopath Chiropractor Acupuncturist

SUBSTANCE SURVEY

Please list any vitamins, supplements, herbs or other homeopathic medicines you are currently taking or have taken in the last year. (Use other side if necessary).

Product	Amount Taken	How Long Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check the following items which apply to you and indicate the amount used (i.e. 3 times a day, daily, weekly, monthly):

- Coffee _____
- Tea _____
- Candy _____
- Ice Cream _____
- Antacids _____
- Soft Drinks _____
- Cigarettes _____
- Recreational Drugs _____
- Alcohol _____
- Laxatives _____
- Other Tobacco Products _____

How many desserts do you have a week? _____

FOOD AND HABITS SURVEY

Eat Fast Food Y N How often? _____ Eat Pork Y N How often? _____
 Eat Shell Fish Y N How often? _____ Eat White Flour Y N How often? _____
 Eat White Sugar Y N How often? _____

My Daily Diet typically consist of:

Vegetables	% of diet _____	Rice, Breads, Cereals	% of diet _____
Lean Meats (poultry, fish)	% of diet _____	Meat (beef, pork, game)	% of diet _____
Fruits	% of diet _____	Nuts, Beans, Seeds	% of diet _____

Daily water intake: How many glasses a day? _____

Exercise	Y	N	How Often? _____
Eat organically	Y	N	How Often? _____
Do you eat after 7:30 PM?	Y	N	How many times a week? _____
Prescription medicine?	Y	N	How many different meds? _____
Over the counter medicine?	Y	N	How often? _____

PERSONAL HISTORY SURVEY

Do you suffer from any of the following? Please summarize your personal experience after each category.

HEAD

Headaches	Y	N	Migraines	Y	N	Frequency? _____
Pressure	Y	N	Dizziness	Y	N	Fainting Y N

Summarize: _____

MIND

Poor memory	Y	N	Poor Concentration	Y	N
Confusion	Y	N	Poor Coordination	Y	N

Summarize: _____

EARS

Itchy Ears	Y	N	Ear Aches	Y	N
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Summarize: _____

EYES

Blurred Vision	Y	N	Watery, Itchy Eyes	Y	N
Swollen Eyelids	Y	N	Dark Circles	Y	N

Are these symptoms seasonal or constant? _____

Summarize: _____

NOSE

Stuffy Nose	Y	N	Sinus Problems	Y	N
Excessive mucous	Y	N	Sneezing Attacks	Y	N

Are these symptoms seasonal or constant? _____

Summarize: _____

LUNGS

Shortness of breathe	Y	N	Need to Clear Throat	Y	N
Asthma	Y	N	Chronic Cough	Y	N
Difficulty Breathing	Y	N			

Are these symptoms seasonal or constant? _____

Summarize: _____

DIGESTIVE

Nausea	Y	N	Constipation	Y	N	Loose stools	Y	N
Bloating/Gas	Y	N	Indigestion	Y	N	Heartburn	Y	N
Poor appetite	Y	N						

Summarize: _____

SKIN

Acne	Y	N	Eczema	Y	N	Cirrhosis	Y	N
Excessive Sweating	Y	N	Hives, dry skin	Y	N	Cold sores	Y	N
Dermatitis	Y	N	Other Rashes	Y	N			

Summarize: _____

JOINT / MUSCLES

Joint Pain	Y	N	Feeling Weak	Y	N	Numbness	Y	N
Joint swelling	Y	N	Stiffness	Y	N			

Summarize: _____

WEIGHT

Emotional Eating	Y	N	Craving certain foods	Y	N	Excessive Weight	Y	N
Compulsive Eating	Y	N	Water Retention	Y	N	Underweight	Y	N

Summarize: _____

EMOTIONS

Mood Swings	Y	N	Anxiety, fear, nervous	Y	N			
Anger, irritability	Y	N	Depression	Y	N	Apathy / lethargy	Y	N

Summarize: _____

ENERGY / ACTIVITY

Fatigue	Y	N	Insomnia	Y	N
Hyperactivity	Y	N	Restlessness	Y	N

Summarize: _____

WOMEN ONLY

P.M.S.	Y	N	Hot Flashes	Y	N
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Summarize: _____

OTHER

Allergies	Y	N	Other sensitivities	Y	N
Body Pain	Y	N	Sexual dysfunction	Y	N
Night sweats	Y	N	Frequent Illness	Y	N
Leaky bladder	Y	N	Genital Itch	Y	N
Frequent or urgent urination	Y	N			

Summarize: _____

CONSTITUTIONAL ANALYSIS

Reported Stress Level (out of 10) _____ Reported Anxiety Level (out of 10) _____ is this normal for you? _____

How do you feel stress in our body physically? Muscular Tension Headaches Grind Teeth
 Digestive Disturbances _____ Compulsive Movements (i.e. nail biting)

Do you frequently feel? Fearful Timid/Shy Irritable Sad Impulsive
 Easily Excitable Angry Obsessive/Worried
 Absent Minded/Dull/Confused Weepy Critical Withdrawn

How does your mood change when your symptoms flare up? _____

Any sensation in your body of? Heaviness Dullness Heat Cold
 Numbness Bloating

Where do you feel this sensation? _____

Women (only) – do you experience any of the following with your periods: Excessive bleeding/Clots

Irregular cycles Absent Menstruation Cycles longer than 4-5 days
 Excessive Pain Severe Mood Swings Fainting Nausea/Vomiting
 Low Back Pain or Hip areas Other _____

List your Top 3 Symptoms/Complaints, in order of importance to you:

Duration of complaint: Since ___/___/___

Number of years: _____

What do you believe caused this condition?

What in your life, brings you JOY?

Are you currently under the care of a physician? _____

For what purpose? _____

Diagnosis given by doctor _____

Your Doctor's Name _____

Phone number _____

What else do you want us to know :

Client Signature: _____

Date: _____

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