CLIENT WELLNESS HISTORY QUESTIONNAIRE

All inquiries on this form are voluntary. Your responses will be kept private and will be used to support you in reaching your well-being goals.

Name: _____

Address: _____

Home Phone:_____ Cell: _____ Email: _____

Gender: _____ Marital Status: _____ DOB: _____

Height: _____ Weight: _____ Occupation: _____

Were you referred? If so, by whom? _____

HEALTHCARE TEAM

Please list the types of healthcare providers you are currently seeing or have recently seen (ex: primary care doctor, psychiatrist, naturopath, therapist, dermatologist, etc) and the date you last saw them.

TYPE OF HEALTHCARE PROVIDER	DATE OF LAST VISIT

MEDICATIONS & SUPPLEMENTS

Please list any medications, vitamins, and/or natural supplements that you are taking along with the amount/frequency and reason for taking them.

NAME	AMOUNT / FREQUENCY	REASON

Do you currently apply any type of hormonal cream? _____

SURGERIES, PROCEDURES, AND RECENT TREATMENTS OR THERAPIES

Please list any surgery, procedure, treatment, recent therapies, and any other relevant information.

DATE	SURGERY, PROCEDURE, TREATMENT	ADDITIONAL INFO

PAST WELLNESS HISTORY

Known allergies: _____

Females, what was the date of your last menstrual period? _____ Are you pregnant? _____

Please list any other information that will help me to better understand your wellness history. Women, please include information about pregnancy and/or childbirth (include dates).

_____

_____

_____

FAMILY INFORMATION

Please list any information about your family's wellness history that you sense is relevant to know.

_____

_____

_____

REASON FOR YOUR VISIT

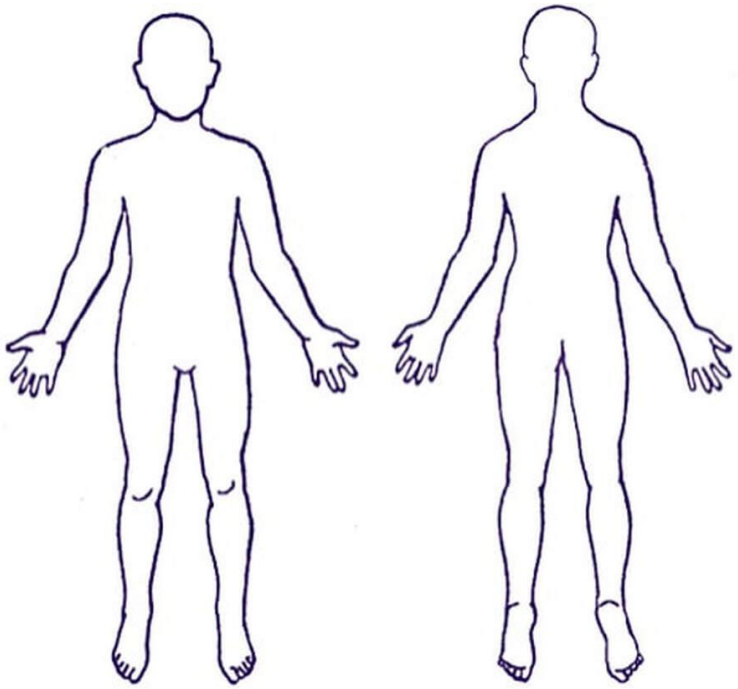
What motivated you to schedule a session? _____

_____

What are your expectations for our work together? _____

_____

Please use diagrams below to indicate areas of focus:



CHECK ALL OF THE FOLLOWING THAT APPLY TO YOUR PAST AND PRESENT LIFE EXPERIENCES. PLEASE FEEL FREE TO ADD COMMENTS FOR CLARIFICATION.

MUSCOSKELETAL

- ☐ Joint Stiffness/Swelling
- ☐ Spasms/Cramps
- ☐ Strains/Sprains
- ☐ Neck Pain
- ☐ Upper/Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder, Arm, Hand Pain
- ☐ Hip, Leg, Foot Pain
- ☐ Numbness/Weakness
- ☐ Problems Walking
- ☐ Headaches
- ☐ Jaw Pain
- ☐ Bone or Joint Problems
- ☐ Other _____
  _____

CIRCULATORY / RESPIRATORY

- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Fainting
- ☐ Cold Hands/Feet
- ☐ Cold Sweats
- ☐ Chills
- ☐ Swollen Ankles
- ☐ Difficulty Lying Flat
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Heart Problems/Chest Pains
- ☐ Palpitations
- ☐ Sinus Problems
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Wheezing
- ☐ Excessive Bleeding
- ☐ Pacemaker
- ☐ Other _____
  _____

GASTROINTESTINAL

- ☐ Gum Bleeding
- ☐ Nervous Stomach
- ☐ Indigestion
- ☐ Heartburn/Reflux
- ☐ Nausea/Vomiting
- ☐ Sporadic Bowel Patterns
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Gallbladder Problems
- ☐ Other _____
  _____

NERVES/EYES/ENT

- ☐ Numbness/Tingling
- ☐ Loss of Strength/ Weakness
- ☐ Paralysis
- ☐ Twitching
- ☐ Persistent Pain
- ☐ Problems Sleeping
- ☐ Seizures
- ☐ Fatigue
- ☐ Visual Impairment/ Double Vision
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Other _____
  _____

SKIN

- ☐ Rashes
- ☐ Itching/Burning
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic Surgery
- ☐ Other _____
  _____

REPRODUCTIVE/URINARY

- ☐ Burning while urinating
- ☐ Excessive Nighttime Urination
- ☐ Blood in Urine
- ☐ Sexual Dysfunction
- ☐ Abnormal Discharge
- ☐ Bladder Leakage
- ☐ Pregnancy
- ☐ Premenstrual Syndrome
- ☐ Menopause
- ☐ Pelvic Inflammation
- ☐ Hysterectomy
- ☐ Fertility Concerns
- ☐ Other _____
  _____

OTHER

- ☐ Loss of Appetite
- ☐ Forgetfulness/Memory Loss
- ☐ Confusion
- ☐ Depressed State of Being
- ☐ Anxious State of Being
- ☐ Weight Loss/Gain
- ☐ Fever
- ☐ Loss of Hair
- ☐ Hot/Cold Intolerance
- ☐ Difficulty Concentrating
- ☐ Hearing Impaired
- ☐ Other _____
  _____
  _____

SOCIAL HISTORY

Do you drink alcohol? _____ If yes, what type and amount per week? _____
_____

Do you currently, or have you ever, smoked or used tobacco? _____ If yes, what form, how often, and amount per day? _____

Do you use recreational drugs? _____ If yes, what type and how often? _____

Do you consume caffeine? _____ If yes, what form and estimated amount per day? _____

Do you exercise? _____ Describe: _____

What are your top 3-5 favorite foods? _____

What do you typically drink for beverages throughout the day? _____

What time do you go to bed? _____ How much do you sleep per night? _____

What position do you sleep in? _____

Do you have regular daily bowel movements? _____ If not daily, how often per week? _____

What are your hobbies? _____

How many hours per day do you perform: Lifting ____ Sitting ____ Bending ____ Screen time ____

Do you experience an abnormally high amount of stress? If yes, from what sources? _____
_____

Are you truly ready for a lifestyle change? ____ If no, what is holding you back and what support do you need to achieve your goals? _____
_____

PLEASE READ AND SIGN BELOW
Bio-Energetic Scanning / Wellness Evaluation Authorization and Release Form

Bioenergetic health evaluation provides an opportunity to measure electrical responses and meridian flow of the body. Bioenergetic evaluation of the energy flow helps identify various stressors that might impede the electrical process. Bio-nutritional assessments and muscle testing provide an opportunity to assess energy balance of the body. These evaluations may include recommendations for natural tinctures, stress reduction methods and/or nutritional changes designed to balance the energy meridians and enhance overall wellness. These recommendations are not cures for any known diseases, nor have they been clinically proven to eliminate any specific disease process. **The bioenergetic evaluation with Zyto Elite is not a method of diagnosing, nore are the suggested tinctures designed to replace any of the medications or treatments currently being provided by a primary care practitioner.**

1. I fully understand that the attending consultant/traditional naturopath is not an allopathic doctor (MD) and does not pretend to be but is providing services that are not allopathic, but that are within the parameters of a natural health and wellness philosophy. The attending consultant's studies include Bioenergetics, Traditional Naturopath, and Complementary Alternative Health Practitioner.
2. I fully understand the attending consultant does not offer allopathic drugs, surgery, chemical stimulants or radiation therapy, but is providing information and natural products to restore natural balance and optimum conditions for health and wellness based on the scope of her practice.
3. I fully understand that the consultant is not diagnosing or treating any illness or disease but is only measuring the bioenergetic balance and overall stress response of the body and that these services may not be generally accepted and/or recommended by allopathic physicians or other health professionals.
4. I fully understand the attending consultant is in no way encouraging me to terminate or modify any previous or ongoing therapies under the direction of any license practitioner, and that the attending consultant can/will not dissuade me from seeking allopathic attention, recommendation or modes of therapy from a license practitioner.
5. I presently seek consultations, advice, opinions, and/or programs, tests, evaluations and/or products within the scope of the attending consultant's wellness practice based upon the principles of bioenergetic health and have solicited the attending consultants services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select that I understand is most beneficial to my health.
6. If I am accompanied by a minor or an incompetent, I give full faith that I am legally and totally responsible for them.
7. I authorize the attending consultant to provide her services to me on my behalf, and hereby release her from any and all claims and potential claims arising out of my actions or failure to act upon her advice.
8. I authorize Heal Well to seek collaboration with other practitioners concerning matters that pertain to my appointments at Heal Well, for the purpose of fainting knowledge or presenting as a case study.
9. I give full faith that I have read and understood this document entirely, that I have received a verbal explanation of the same from the attending consultant, and that she has satisfactorily answered all of my questions regarding this form.
10. I am willing to declare and repeat under oath all of the above statements by request of the attending consultant.

A CNHP/ CAHP student is a complementary and alternative health practitioner, not a licensed medical provider. Information and education provided by the CNHP/ CAHP student does NOT constitute medical or mental health advice and is not intended to be a substitute for professional medical advice, diagnosis, or treatment of any kind. Do not disregard or delay seeking professional medical advice because of information provided to you by the CNHP/ CAHP student. A session with your CNHP/ CAHP student is not intended to be a substitute for medical visits, advice, diagnosis, or treatment from a licensed healthcare professional. Do not stop taking any medications without speaking to your physician or other qualified healthcare professional regarding any questions or concerns you have about your health and any illness, disease, or condition.

I acknowledge I have voluntarily given personal information regarding my wellness history and well-being goals for the CNHP/ CAHP student's use. I understand my information is processed according to Heal Well's client services agreement, and I give my consent for Heal Well to store and use my information.

I understand that, if I have been untruthful with my information or if I fail to give enough relevant information about my wellness history, that my choices could affect the success of my work with the CNHP/ CAHP student.

Client or Guardian Signature_____

Date _____