Energetic Living Digestive & Symptom Health Assessment

INSTRUCTIONS

My goal is a Certified Digestive Health Professional and Nutrition Practitioner is to find how to best support the body, support healing within the Innate Intelligence of the body and find underlying imbalances that may be affecting your health.
Please read and follow these instructions carefully:

1. Please allow yourself plenty of time to thoroughly complete this form as the questions and your responses are critical for getting to the root cause of your health concerns and correcting them.

2. Please be very detailed with your responses. Include everything – even if you think it's small and insignificant – as this is often where the real answers are found. If your responses are not detailed enough we will need to spend time on them during your session, which will take away from the time available to create a personalized health plan for you.

3. If you aren't sure how to respond to a question, please put forth your best effort and we can address it during your first coaching session.

4. Rest assured that your information, including your responses here, is private and will not be shared without your express written permission.

5. Once your Transformational Nutrition Health Assessment Form is complete, please return it to at least 72 hours before your first session.

RECENT HEALTH TESTS
Please bring copies of any health tests (including blood tests, food sensitivity panels, genetic test results, etc.) that have been conducted in the last 12 months to your first session.

Sincerely,

Rene Deal,
Certified Emotion & Body Code Practitioner
Certified Digestive Health Professional
Certified Nutrition Transformational Nutrition Coach

GENERAL INFORMATION

Date: _____

Name: _____
First Middle Last

Age: _____ Gender: ☐ Female ☐ Male

Primary Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email: _____ Preferred Method of Contact: _____

Emergency Contact Name and Best Way To Contact:

_____

Primary Care Physician:

_____
Name Phone Number

Ethnicity and/or Genetic Background:

_____

_____

_____

Highest Education Level: ☐ High School ☐ Undergraduate ☐ Post Graduate

Job Title: _____ #Hours Worked Per Week: _____

Nature of Business: _____

Describe the physical exercise or movement you do per week and in what form?

_____

_____

_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Long Term Relationship

CURRENT HEALTH STATUS

Please provide information on current and ongoing health concerns.

CONCERN	DATE OF ONSET	SEVERITY/ FREQUENCY	TREATMENT	LEVEL OF SUCCESS
Ex: Leaky Gut	*June 2013*	*Severe pain and lethargy after meal*	*AIP Diet*	*Completely resolved then but symptoms sometimes now after eating*

What diagnosis or explanation(s) have been given to you for these concerns?

_____

_____

_____

What physician or other health care provider (alternative or otherwise) have you seen for these concerns?

_____

_____

What makes you feel better? _____

What makes you feel worse? _____

If I could wave a magic wand and grant you three wishes, what would they be?

1. _____

2. _____

3. _____

What do you think is at the root of your symptoms/diagnoses?

What treatment(s) do you think could solve your problems?

What do you think your body needs to heal (trust your intuition here)?

When was the last time you felt great?

What else was going on in your life at that time? (Please include information on your diet, workout, physical activity, job, relationships, and any additional details you remember.)

MEDICAL HISTORY

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy).*

Past	Ongoing	DIGESTIVE/GASTROINTESTINAL
		Irritable Bowel Syndrome
		Inflammatory Bowel Disease
		Crohn's Disease
		Ulcerative Colitis
		Gastritis or Peptic Ulcer Disease
		GERD (Reflux)
		Celiac Disease
		Gallstones
		Hemorrhoids or Anal Fissures
		Diverticulitis or Diverticulosis
		Other

Past	Ongoing	CARDIOVASCULAR
		Heart Attack
		Heart Disease
		Stroke
		Elevated Cholesterol
		Arrhythmia (Irregular Heartbeat)
		Hypertension (High Blood Pressure)
		Coronary Artery Disease
		Cardiomyopathy
		Other

Past	Ongoing	ENDOCRINE/METABOLIC
		Type 1 Diabetes
		Type 2 Diabetes
		Hypoglycemia
		Metabolic Syndrome
		Insulin Resistance or Pre-Diabetes
		Hypothyroidism (Low Thyroid)
		Hyperthyroidism (Overactive Thyroid)
		Hashimoto's
		Endocrine Problems
		Adrenal Disorders (Please Specify)
		Other

Past	Ongoing	CANCER
		Lung Cancer
		Breast Cancer
		Colon Cancer
		Ovarian Cancer
		Prostate Cancer
		Skin Cancer
		Other

Past	Ongoing	GENITAL & URINARY SYSTEMS
		Kidney Stones
		Bladder Control Issues
		Gout
		Candida
		Cysts
		Frequent Urinary Tract Infections
		Frequent Yeast Infections
		Erectile or Sexual Dysfunction
		STD (Please specify)
		Other

Past	Ongoing	DIGESTIVE/GASTROINTESTINAL
		Chronic Fatigue Syndrome
		Autoimmune Disease
		Rheumatoid Arthritis
		Lupus
		Colitis
		Immune Deficiency Disease
		Graves' Disease
		Addison's Disease
		Poor Immune Function (Frequent colds or infections)
		Food Allergies
		Environmental Allergies
		Multiple Chemical Sensitivities
		Latex Allergy
		Hepatitis
		Other

MEDICAL HISTORY *(Continued)*

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy).*

Past	Ongoing	MUSCULOSKELETAL/PAIN
		Osteoarthritis
		Fibromyalgia
		Bone Fractures
		Chronic Pain
		Joint Pain
		Other

Past	Ongoing	RESPIRATORY DISEASE
		Asthma
		Chronic Sinusitis
		Bronchitis
		Emphysema
		Pneumonia
		Tuberculosis
		Sleep Apnea
		Other

Past	Ongoing	SKIN DISEASE
		Eczema
		Psoriasis
		Acne
		Rosacea
		Dermatitis
		Other

Past	Ongoing	MISCELLANEOUS
		Anemia
		Chicken Pox
		German Measles
		Measles
		Mononucleosis
		Mumps
		Sleep Apnea
		Whooping Cough

Past	Ongoing	NEUROLOGICAL/MOOD
		Depression
		Anxiety
		Bipolar Disorder
		Schizophrenia
		Headaches
		Migraines
		ADD/ADHD
		Autism
		Mild Cognitive Impairment
		Memory Problems
		Parkinson's Disease
		Multiple Sclerosis
		ALS
		Seizures
		Alzheimer's
		Other

Past	Ongoing	WEIGHT/EATING DISORDERS
		Abnormal Weight Gain
		Abnormal Weight Loss
		Bulimia
		Anorexia
		Binge Eating Disorder
		Night Eating Disorder
		Eating Disorder (Non-Specific)
		Other

MEDICAL HISTORY *(Continued)*

Check appropriate box and provide date of test/injuries/surgeries (mm/yyyy).

HOSPITALIZATION/SURGERIES

Please provide a full history of any surgeries or hospitalizations below:

DATE	SURGERY/HOSPITALIZATION	TREATMENT APPROACH	SUCCESS

TEST RESULTS/LABS

Please indicate any tests you have had performed in the last 18 months. Examples include a full physical exam, X-Ray, MRI, ultrasound, cardiac stress test, mammography, blood work, genetic testing, etc.

DATE	TEST/LAB	RESULTS

HOSPITALIZATION

Please indicate any hospital visits or stays you have had and the outcomes.

DATE	REASON	RESULTS

WOMEN'S HEALTH HISTORY

OBSTETRIC HISTORY	
Pregnancies (How many?)	
Postpartum Depression	
Caesarean (How many?)	
Toxemia	
Vaginal Deliveries (How many?)	
Gestational Diabetes	
Miscarriage (How many?)	
Baby over 8 pounds (How many?)	
Abortion (How many?)	
Breastfeeding (If yes, for how long?)	
Living Children	

MENSTRUAL HISTORY			
Age at First Period?	Menses Frequency?	Length?	Pain? ☐ Yes ☐ No
Clotting? ☐ Yes ☐ No	Has Your Period Ever Skipped? ☐ Yes ☐ No		For How Long?
Last Menstrual Period?			
Use of Hormonal Contraception such as Birth Control Pill, Patch, Other? How Long?			
Do you use contraception? ☐ Yes ☐ No			
If yes, what kind? ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy ☐ Other:			

WOMEN'S DISORDERS/HORMONAL IMBALANCES
Do you experience breast tenderness, water retention, irritability or PMS symptoms in the second half of your cycle? Yes ☐ No ☐
Currently, are your periods consistent? ☐ Yes ☐ No
Which PMS Symptoms, if any, do you usually experience? ☐ Cramping ☐ Fatigue ☐ Brain Fog ☐ Mood Swings ☐ Bloating
How do you manage PMS symptoms (i.e., rest, pain meds, etc.)?
When you are not menstruating, how are your energy levels? ☐ Low ☐ Moderate ☐ High
Have you ever had trouble getting pregnant?

Please advise of any other symptoms or conditions that you feel are significant: _____

_____

_____

WOMEN'S DISORDERS/HORMONAL IMBALANCES *(Continued)*

Circle any conditions you have experienced:

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last Mammogram?	Breast Biopsy/Date:	Last PAP Test?
Last Bone Density?	Results: ☐ High ☐ Low ☐ Within Normal Range	
Are you in Menopause? ☐ Yes ☐ No	Age at Menopause?	

Please check off if you are experiencing any of the following symptoms:

☐ Hot Flashes	☐ Mood Swings	☐ Concentration/Memory Problems	☐ Joint Pains
☐ Vaginal Dryness	☐ Decreased Libido	☐ Heavy Bleeding	☐ Headaches
☐ Weight Gain	☐ Incontinence	☐ Palpitations	

Use of hormone replacement therapy? How Long? What Type?

_____

MEN'S HEALTH HISTORY

MEN'S HEALTH

Have you ever had a PSA done? ☐ Yes ☐ No

If yes, PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

Other Conditions:

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

Nocturia (Urination at Night)? ☐ Yes ☐ No	If yes, how many times a night?
Loss of control of Urine? ☐ Yes ☐ No	Urgency/Hesitancy/Change in Urinary System? ☐ Yes ☐ No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Start Date	Reason for Use

PREVIOUS MEDICATIONS
(Last 10 Years)

Medication	Dosage	Frequency	Start Date	Reason for Use

NUTRITIONAL SUPPLEMENTS
(VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement & Brand	Dosage	Frequency	Start Date	Reason for Use

Do your medications or supplements ever cause unusual side effects or problems? ☐ Yes ☐ No
Describe: _____
Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No
Frequent antibiotics > 3 times/year ☐ Yes ☐ No
Long term antibiotics ☐ Yes ☐ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

CHILDHOOD HISTORY

To the best of your knowledge...	Yes	No	Don't Know	Comments
Were you a full term baby?	☐	☐	☐	
A premature birth?	☐	☐	☐	
Vaginal Delivery?	☐	☐	☐	
C-Section?	☐	☐	☐	
Breast-fed?	☐	☐	☐	
Bottle-fed?	☐	☐	☐	
When pregnant with you, did your mother:				
Smoke tobacco?	☐	☐	☐	
Use recreational drugs?	☐	☐	☐	
Drink alcohol?	☐	☐	☐	
Use estrogen?	☐	☐	☐	
Other prescription or non-prescription medications?	☐	☐	☐	

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comments
Sugar (Sweet Foods, Candy, Cookies, etc.)?	☐	☐	☐	
Soda?	☐	☐	☐	
Fast food, pre-packaged or artificial foods?	☐	☐	☐	
Milk, cheese, or other dairy products?	☐	☐	☐	
Meat, Vegetables, & Potato Diet	☐	☐	☐	
Vegetarian Diet?	☐	☐	☐	
Diet high in wheat (breads, cereals, pasta)?	☐	☐	☐	

As a child, were there foods that you had to avoid due to unwanted side effects? ☐ Yes ☐ No

If yes, please explain: _____

_____

As a child did you have a high absence from school?

If yes, why? _____

_____

Experience chronic exposure to second hand smoke in your home? ☐ Yes ☐ No
Experience physical or emotional abuse? ☐ Yes ☐ No
Witness physical or emotional abuse? ☐ Yes ☐ No
Have alcoholic parents? ☐ Yes ☐ No
Have parents who used or were addicted to drugs? ☐ Yes ☐ No
Experience the death of a parent or loved one? ☐ Yes ☐ No

CHILDHOOD ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages: birth to 12 years) and the approximate age of onset.

Childhood Illness	Yes	Age
ADD (Attention Deficit Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital Problems		
Ear Infections		
Fever Blisters		
Frequent Colds or Flu		
Frequent Headaches		
Hyperactivity		
Jaundice		

Childhood Illness	Yes	Age
Mumps		
Pneumonia		
Seasonal Allergies		
Skin Disorders		
Strep Infections		
Tonsillitis		
Upset Stomach/Digestive Problems		
Whooping Cough		
Measles		
Other (Describe)		
Other (Describe)		
Other (Describe)		

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge. Please check family members that apply.

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Age (if still living)									
Heart Attack									
Age at death (if deceased)									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

FAMILY HEALTH HISTORY *(Continued)*

Please indicate current and past history to the best of your knowledge. Please check family members that apply.

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

DENTAL HISTORY

	Yes	No
Problem with sore gums (gingivitis)?		
Ringing in the ears (tinnitus)?		
Have TMJ (temporal mandibular joint) problems?		
Metallic taste in mouth?		
Problems with bad breath (halitosis) or white tongue (thrush)?		
Previously or currently wear braces?		
Problems chewing?		
Floss regularly?		
Do you have amalgam dental fillings? How many?		
Did you receive these fillings as a child?		
Do you have gold fillings?		
Have you had a root canal(s)?		
Implants?		
Tooth pain?		
Bleeding gums?		
Gingivitis?		

List your approximate age and the type of dental work done from childhood until present:

Age	Type of Dental Work:	Health Problems Following Dental Work? (Describe)

NUTRITIONAL HISTORY

How much of the following do you consume each week?

Candy or Sweets (foods containing sugar)	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Diet soda	
Ice cream	
Salty foods	
Slices of white or wheat bread (please specify rolls, bagels, etc.)	
Soda with caffeine	
Soda without caffeine	
Cups of tea containing caffeine	

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

If yes, circle below:

Gluten-Free ☐ Diabetic ☐ Dairy Restricted ☐ Vegetarian ☐ Vegan ☐ Blood type diet

Other: _____

Is anything special about your diet that I should know? _____

_____

_____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? _____

_____

If yes, have you associated these symptoms with any particular food or supplement? Please name the food or supplement and symptom(s). _____

_____

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc.? (Symptoms may not be evident for 24 hours or more) ☐ Yes ☐ No

DO YOU FEEL WORSE WHEN YOU EAT A LOT OF:	Yes	No
High fat foods		
High protein foods		
High carbohydrate foods (Breads, pasta, potatoes)		
Refined sugar (junk food)		
Fried foods		
1 or 2 alcoholic drinks		
Other:		

DO YOU FEEL BETTER WHEN YOU EAT A LOT OF:	Yes	No
High fat foods		
High protein foods		
High carbohydrate foods (Breads, pasta, potatoes)		
Refined sugar (junk food)		
Fried foods		
1 or 2 alcoholic drinks		
Other:		

NUTRITIONAL HISTORY *(Continued)*

Does skipping meals greatly affect your symptoms and the reason you are seeking coaching? ☐ Yes ☐ No

Has there ever been a food that you have craved or 'binged' on over a period of time? ☐ Yes ☐ No
If yes, what food(s): _____

How many times do you chew your food? _____
How much fluid do you drink with your meals? _____
How many servings of fruits & vegetables do you eat per week? _____
What foods do you dislike? _____
What foods do you not tolerate well or do you react to? _____
What type of cuisine do you like? _____
What is your typical breakfast? _____
How much time do you have in the morning to prepare breakfast? _____
What is your typical lunch? _____
What is your typical dinner? _____
What meats do you eat? _____
Do you eat eggs? _____
Do you ever do vegetarian? If so, how often? _____
What foods do you crave? _____
Do you have snacks during the day? If so what do you snack on? _____
Do you eat fish or other seafood? If so what types? _____
Do you eat dessert? If so what do you eat? _____
Do you skip any meals? _____
What time do you eat your breakfast, lunch, dinner? _____
What time do you usually eat snacks? _____
What types of beverages do you consume? _____
How many ounces/mls of water do you consume daily? _____
What oils do you cook with? _____

Caffeine Intake: ☐ Yes ☐ No
If yes:
Coffee Cups/day: ☐ 1 ☐ 2-4 ☐ >4 per day
Tea Cups/day: ☐ 1 ☐ 2-4 ☐ >4 per day

Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No
If yes:
12-ounce can/bottle: ☐ 1 ☐ 2-4 ☐ >4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____
_____

DIGESTIVE HISTORY

Foreign Travel? ☐ Yes ☐ No If yes, where? _____

Wilderness Camping? ☐ Yes ☐ No If yes, where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

Please complete the following charts as it relates to your bowel movements:

FREQUENCY	
More than 3x a day	
1-3x a day	
4-6x a week	
2-3x a week	
1 or fewer x a week	

COLOR	
Medium brown consistently	
Very dark or black	
Greenish color	
Blood is visible	
Varies a lot	
Dark brown consistently	
Yellow, light brown	
Greasy, shiny appearance	

CONSISTENCY	
Soft and well-formed	
Often floats	
Difficult to pass	
Diarrhea	
Thin, long, or narrow	
Small and hard	
Loose but not watery	
Alternating between hard and loose/watery	

INTESTINAL GAS	
Daily	
Occasionally	
Excessive	
Present with pain	
Foul smelling	
Little odor	

LIFESTYLE HISTORY

SMOKING

Currently Smoking: ☐ Yes ☐ No How many years? _____ Packs per day? _____
Attempts to quit: _____
Previous Smoking: ☐Yes ☐No How many years? _____ Packs per day? _____
Second Hand Smoke? _____

ALCOHOL INTAKE

How many drinks currently per week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 If "None," skip to the Marijuana and CBD Section

Previous alcohol intake? ☐Yes (Mild☐Moderate☐High)☐ ☐ No

Does alcohol seem to affect you differently than it does other? If yes, how so? _____

_____

_____

Have you been told you should cut down your alcohol intake? _____
Do you get annoyed when people ask you about your drinking? _____
Do you feel guilty about your alcohol consumption? _____
Do you notice a tolerance to alcohol (can you hold more than others)? _____
Have you ever been unable to remember what you did during a drinking episode? _____
Do you get into arguments or physical fights when you have been drinking alcohol? _____
Have you ever been arrested or hospitalized because of drinking? _____
Have you ever thought about getting help to control or stop your drinking? _____

MARIJUANA, CBD, AND OTHER SUBSTANCES

Do you currently use marijuana? If so, how much and how often? _____

_____

What form(s) of marijuana do you use? (Edibles, oil, wax, herb/flower, etc.) _____

_____

Do you currently use CBD? If so, what dosage and how often? _____

_____

What benefits do you notice from using marijuana or CBD? _____

_____

Other Substances (Please be thorough and remember, your responses are confidential.)

_____

_____

Are you currently using any recreational drugs? ☐ Yes ☐ No
If yes, please specify the drug, dosage, and frequency. _____

_____

Have you ever used IV or inhaled recreational drugs? _____
If you have used IVs, did you ever share needles? _____
If you shared needles, have you been tested for HIV and Hepatitis C? _____

ENVIRONMENTAL & DETOXIFICATION ASSESSMENT

Do you use environmentally friendly household products? ☐Yes ☐No
Do you eat primarily organic foods? ☐Yes ☐No
Do you have known adverse food reactions or sensitivities? ☐Yes ☐No
If yes, describe symptoms: _____

_____

Do you have any food allergies or sensitivities? ☐Yes ☐No
If yes, list all: _____

_____

DO YOU ADVERSELY REACT TO *(Check All That Apply)*	
	Monosodium Glutamate (MSG)
	Aspartame (Nutrasweet)
	Caffeine
	Bananas
	Garlic
	Onion
	Cheese
	Chocolate
	Alcohol
	Red Wine
	Citrus Foods
	Sulfite containing foods (wine, dried fruit, salad bars)
	Preservatives (ex. Sodium Benzoate)
	Other:

DO YOU HAVE A KNOWN HISTORY OF SIGNIFICANT EXPOSURE TO ANY HARMFUL CHEMICALS, SUCH AS THE FOLLOWING: *(If Yes, Include Details)*	
Insecticides (Frequent visits of exterminator)	
Pesticides	
Organic Solvents	
Lead	
Arsenic	
Aluminum	
Cadmium	
Mercury	
Other:	

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? _____
Do you or have you been exposed to mold? _____
Do you have any pets or animals? ☐Yes ☐No
If yes, what kind of pets? _____
Is the pet an indoor or outdoor pet? _____
Does the pet sleep with you? _____

TOXIN/CONTAMINANT EXPOSURE

Have you ever used toxic household cleaners? ☐Yes ☐No How many years? _____Times per week? _____
Do you currently use toxic household cleaners? ☐Yes ☐No If yes, how many times per week? _____
As a child, were you frequently (> 1 per week) exposed to toxic household cleaners? ☐Yes ☐No
Do you currently live on or near a non-organic farm? ☐Yes ☐No
Have you ever lived on or near a non-organic farm (including childhood)? ☐Yes ☐No
If yes, when? _____ Number of years _____
Do you eat non-organic produce? ☐Yes ☐No Times per week _____
Have you ever eaten non-organic produce? ☐Yes ☐No Number of years_____ Times per week _____
Do you eat conventionally raised animal products? ☐Yes ☐No Times per week_____
Do you consume fast foods or foods with additives, artificial flavors and preservatives? ☐Yes ☐No
If yes, how many times per week? _____
Have you ever lived in a very old home? ☐Yes ☐No When? _____Number of years _____
Have you ever lived in a brand-new home? ☐Yes ☐No When? _____
Does your current home have carpet? ☐Yes ☐No
Does your home or workplace have cracking paint, visible mold, or water damage? ☐Yes ☐No
Have you been exposed to lead paint or treated lumber? ☐Yes ☐No
Do you drink filtered/purified/distilled water? ☐Yes ☐No
Does the water that you regularly drink contain fluoride? ☐Yes ☐No
Do you live or work near a highway, factory, gas station, or power plant? ☐Yes ☐No
Do you sleep near a Wi-Fi source, cell phone, or laptop? ☐Yes ☐No
Do you live or work near a cell phone tower or high-voltage power lines? ☐Yes ☐No

Are you highly sensitive to smoke, perfumes, gasoline, and other toxic fumes? ☐ Yes ☐ No

If yes, explain: _____

Have you had extensive dental work done, including fillings, root canals, and dentures? ☐ Yes ☐ No

If yes, explain: _____

Have you ever heavily consumed alcohol or recreational or prescription drugs? ☐ Yes ☐ No

Number of prescription drugs you currently take: _____

Do you frequently (>2 times per year) use antibiotics? ☐ Yes ☐ No

Did you frequently (>2 times per year) use antibiotics as a child? ☐ Yes ☐ No

Do you ever walk barefoot in public parks or other potentially fertilized land? ☐ Yes ☐ No

If yes, how many times per month? _____

What type/brands of personal care products do you use (Deodorant, Lotion, Soaps)? _____

_____

_____

SYMPTOMS

Please indicate frequency of symptoms: **0** = Never / **1** = Rarely / **2** = Moderate (Weekly) / **3** = Severe (Daily)

CATEGORY 1: STOMACH SUPPORT	0	1	2	3
1. Heartburn or acid reflux				
2. Excessive burping or bloating				
3. Bad breath				
4. Burping, bloating, or gas after eating				
5. Difficult bowel movements				
6. Sense of fullness after meals				
7. Undigested food in stool				
8. Stomach pain or burning 1-4 hours after meal				
9. Feeling relief after antacid use				
10. Feel hungry soon after eating				
11. Digestive problems vanish after rest				
12. Heartburn after eating spicy foods, chocolate, citrus, or caffeine				
13. Strong odor from sweat				
14. Feel better when not eating				
15. Fingernails chip or break easily				
16. Stomach pain or cramps in general				
17. Diarrhea, chronic				
18. Diarrhea, after meals				

CATEGORY 2: INTESTINAL SUPPORT	0	1	2	3
19. Constipation after eating fiber and roughage				
20. Feel full 2-4 hours after eating				
21. Excess gas				
22. Frequent urination				
23. Foul-smelling, mucous coated, greasy stool				
24. Nausea and/or vomiting				
25. Increasing frequency of food reactions/allergies				
26. Aches, pains, and swelling in body				
27. Frequent bloating and distention after eating				
28. Bloating after eating sugar or starches				
29. Food allergies				
30. Airborne allergies				
31. Hives or welts on skin after eating				
32. Gluten sensitivity				
33. Dairy sensitivity				
34. Sinus congestion				
35. Craving for pasta and bread				
36. Alternating constipation and diarrhea				
37. Tend to “zone out” after eating				
38. Increased pulse after eating				

CATEGORY 3: LIVER & GALLBLADDER SUPPORT	0	1	2	3
39. High-fat or greasy foods upset stomach				
40. Gas and/or bloating several hours after eating				
41. Bitter metallic taste in mouth, especially in the morning				
42. Fishy-tasting burps after consuming fish oils				
43. Difficulty losing weight				
44. Eyes have yellowish color				
45. Color of stool alternates from normal brown to clay color				
46. Skin more red than normal, especially palms				
47. Gallbladder attacks or gallstones				
48. Excessive hair loss				
49. Body swelling for no reason				
50. Weight gain				
51. Nausea				
52. Pain between shoulder blades				
53. Age or “liver” spots				
54. Motion sickness				
55. Headache over eyes				
56. Insomnia				
57. Sensitivity to perfume, chemicals, etc.				
58. Easily intoxicated				
59. Pain under rib cage on right side				
60. Hemorrhoids or varicose veins				

CATEGORY 4: COLON SUPPORT	0	1	2	3
61. Feeling that bowels do not empty completely				
62. Diarrhea				
63. Constipation				
64. Alternating diarrhea and constipation				
65. Stool hard or difficult to pass				
66. More than 3 bowel movements per day				
67. Use laxatives 3 or more times per week				
68. Skip days between bowel movements				
69. Cramping in lower abdomen				
70. Lower abdominal pain relieved by passing stool or gas				
71. Pass large amount of bad-smelling gas				
72. Coated or “fuzzy” tongue				
73. Loose stools				
74. Mucus in stool				
75. Blood in stool				
76. Anus itches				
77. History of parasites				
78. IBS or colitis				
79. Yeast infections				
80. Nail fungus or athletes foot				

CATEGORY 5: VITAMIN & MINERAL DEFICIENCIES	0	1	2	3
81. Nosebleeds				
82. Gums bleed easily				
83. Bruise easily				
84. Body jerks as falling asleep				
85. Heart races				
86. Anxiety or persistent worry				
87. Small bumps on back of arms				
88. Restless leg syndrome				
89. Numbness or tingling in body				
90. Loss of muscle tone				
91. Feeling depressed regularly				

CATEGORY 6: ADRENAL SUPPORT	0	1	2	3
92. Trouble staying asleep				
93. Cravings for salt or salty foods				
94. Slow getting started in the morning				
95. Fatigue in the afternoon				
96. Dizziness when standing quickly				
97. Headaches in the afternoon				
98. Headaches when exercising or exertion				
99. Weak nails				
100. Difficulty falling asleep				
101. Perspire easily even with no activity				
102. Under a high amount of stress				
103. Gain weight when under stress				
104. Wake up tired even after 6 hours or more of sleep				
105. Grind teeth or clench jaw				
106. Hives				
107. Eyes sensitive to bright light				
108. Slow to recover from stress				

CATEGORY 7: THYROID SUPPORT	0	1	2	3
109. Flushes easily				
110. Feel sluggish or tired mentally				
111. Easily fatigued				
112. Cold hands and feet				
113. Low body temperature				
114. Sensitivity to cold				
115. Intolerant to heat				
116. Require excessive amounts of sleep to properly function				
117. Difficulty losing weight				
118. Gain weight easily				
119. Depression or lack of motivation				
120. Seasonal sadness or SAD				
121. Morning headaches that vanish as the day goes on				
122. Thinning of outer third of eyebrow				
123. Hair loss or thinning				
124. Fast pulse at rest				
125. Nervousness and emotional				
126. Insomnia				
127. Heart palpitations				
128. Night sweats				
129. Difficulty gaining weight				

CATEGORY 8: BLOOD SUGAR BALANCE	0	1	2	3
130. Crave sweet foods				
131. Irritable if meals are missed				
132. Depend on coffee or sugar to get/stay going				
133. Get light-headed or headache if meal is delayed				
134. Eating relieves fatigue				
135. Feel shaky or weak when hungry				
136. Easily agitated or nervous				
137. Difficulty remembering things				
138. Blurred vision				
139. Fatigue after meals				
140. Still crave sugar even after eating it				
141. Must have sweets after meals				
142. Waist girth is equal to or larger than hip girth				
143. Frequent urination				
144. Increased thirst and appetite				
145. Difficulty losing weight				

CATEGORY 9: MEN ONLY	0	1	2	3
146. Difficulty urinating or dribbling urination				
147. Pain or burning when urinating				
148. Frequent urination				
149. Pain on inside of legs or heels				
150. Feeling of incomplete bowel emptying				
151. Leg twitching at night				
152. Decreased libido				
153. Decreased number of spontaneous morning erections				
154. Difficulty maintaining morning erections				
155. Decreased fullness of erections				
156. Difficulty or inability to concentrate				
157. Depression				
158. Muscle soreness				
159. Decreased physical stamina				
160. Unexplained weight gain				
161. Increase in fat distribution around hips and chest				
162. Profuse, excessive, uncontrollable sweating				
163. More emotional than in the past				

CATEGORY 10: MENSTRUATING FEMALES ONLY	0	1	2	3
164. Length of menstrual cycle varies				
165. Menstrual cycle greater than 32 days				
166. Menstrual cycle less than 24 days				
167. Pain and cramping during menstrual cycle				
168. Light blood flow during menstrual cycle				
169. Heavy blood flow during menstrual cycle				
170. Breast pain and swelling during menstrual cycle				
171. Pelvic pain during menstrual cycle				
172. Mood swings around and/or during menstrual cycle				
173. Irregular menstrual cycles				
174. Acne around and/or during menstrual cycle				
175. Irritable and/or depressed around and/or during menstrual cycle				
176. Acne, in general not just during and around cycle				
177. Facial hair growth				
178. Hair loss/thinning				
179. Yeast infections				
180. Endometriosis				
181. Uterine fibroids				
182. Fibrocystic breasts				
183. Vaginal itchiness				
184. Vaginal discharge				
185. Night sweats				
186. Menopausal symptoms				
187. Perimenopausal				

CATEGORY 11: MENOPAUSAL FEMALES ONLY	0	1	2	3
188. How many years have you been menopausal?				
189. Since then have you had uterine bleeding? Yes No				
190. Hot flashes				
191. Mental fogginess				
192. Not interested in sex				
193. Mood swings				
194. Depression				
195. Painful intercourse				
196. Facial hair growth				
197. Increased vaginal pain, itching, or dryness				
198. Shrinking breasts				
199. Acne				

CATEGORY 12: IMMUNE SYSTEM	0	1	2	3
200. Easily catch colds or flu				
201. Runny nose or nasal drip				
202. Swollen lymph nodes				
203. Poor wound healing				
204. History of Epstein Barr, Mono, Herpes, Shingles, or Chronic Fatigue				

CATEGORY 13: KIDNEY AND BLADDER	0	1	2	3
205. Pain when urinating				
206. Frequent bladder infections				
207. Cloudy, dark, or bloody urine				
208. Urine has strong odor				
209. History of kidney stones				
210. Dribbling urination				
211. Pain in lower back				
212. Frequent urination				

CATEGORY 14: ELECTROLYTE & PH BALANCE	0	1	2	3
213. Edema and swelling in ankles and wrists				
214. Muscle cramps				
215. Poor muscle endurance				
216. Frequent urination				
217. Frequent thirst				
218. Craving salt or salty foods				
219. Abnormal sweating from minimal activity				

MOVEMENT

Do you exercise regularly? ☐ Yes ☐ No

Current exercise program, if any: (Include type of movement, number of sessions/week, and duration)

_____

_____

_____

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

Where do you complete most of your exercise? _____

Do you enjoy/look forward to exercise? ☐ Yes ☐ No

How do you feel after exercise? _____

Does this feeling differ depending on type of exercise? _____

_____

_____

List any problems that limit movement: _____

_____

_____

NUTRITIONAL LIFESTYLE FACTORS

Height (feet/inches) _____ Current Weight _____

Usual Weight +/- 5lbs. _____ Desired Weight Range (+/- 5lbs.) _____

Highest Adult Weight _____ Lowest Adult Weight _____

Weight Fluctuations (>10 lbs.) _____ Body Fat % _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you grocery shop? ☐ Yes ☐ No

If no, who does the shopping? _____

Do you avoid any particular foods? ☐ Yes ☐ No

If yes, what types and why? _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you cook? ☐ Yes ☐ No

If no, who does the cooking?_____

Do you read food labels? ☐ Yes ☐ No

Do you count calories? ☐ Yes ☐ No

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

CURRENT LIFESTYLE & EATING HABITS

Check all that apply to your current lifestyle

	Erratic Eating Patterns
	Fast eater
	Late night eating
	Dislike healthy food
	Significant other or family members don't like healthy foods
	Eat more than 50% of meals away from home
	Travel frequently
	Non-availability of healthy foods
	Do not plan meals or menus
	Reliance on convenience for food choices
	Poor snack choices
	Time constraints/Busy schedule
	Often stressed during mealtime
	Love to eat
	Eat because I have to
	Have a negative relationship with food
	Struggle with eating issues
	Emotional eater (eat when sad, lonely, depressed, bored)
	Eat too much under stress
	Eat too little under stress
	Don't like to cook
	Eating in the middle of the night
	Confused about nutrition advice
	Significant other or family members have special dietary needs or food preferences
	Eat too much
	Often experience indigestion

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

If yes, explain: _____

_____

_____

PSYCHOSOCIAL & LIFESTYLE FACTORS

Do you feel significantly less vital than you did one year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel capable? ☐ Yes ☐ No

Do you feel confident? ☐ Yes ☐ No

Do you like yourself as you are today? ☐ Yes ☐ No

Identify your biggest success in life: _____

_____

_____

What fueled this success? _____

_____

_____

Identify your biggest failure. _____

What caused this failure? _____

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you tend to focus on your strengths or your weaknesses? ☐ Strengths ☐ Weaknesses

Compared to others, would you say that you have a low or high view of yourself? ☐ High ☐ Low

Do you find it difficult to complete routine daily tasks? ☐ Yes ☐ No

Have you had any major accidents (i.e., car crashes, injuries, etc.)? ☐ Yes ☐ No

Have you ever sought out professional counseling? ☐ Yes ☐ No

If so, what was the outcome? _____

Are you open to receiving professional counseling? ☐ Yes ☐ No

Have you recently made any major life changes (i.e., moving, new job, marriage, etc.)? ☐ Yes ☐ No

If yes, explain: _____

Do you find that there is a strong link between the quality of your sleep and your mood? ☐ Yes ☐ No

Do you believe stress is reducing the quality of your life? ☐ Yes ☐ No

On a 0-10 scale, how would you rate your willpower? _____

Do you like the work you do? ☐ Yes ☐ No

Do you tend to resist change? ☐ Yes ☐ No

Have you ever been exposed to violence? ☐ Yes ☐ No

Have you ever been the target of violence? ☐ Yes ☐ No

Are you currently, or have you ever been, in an emotionally or physically abusive relationship? ☐ Yes ☐ No

Do you often feel overwhelmed by life? ☐ Yes ☐ No

Are you in a safe and secure housing arrangement? ☐ Yes ☐ No

Do you think that your belief system contributes to life outcomes? ☐ Yes ☐ No

Do you find it difficult to trust others? ☐ Yes ☐ No

Do you know how to set personal and professional boundaries? ☐ Yes ☐ No

Do you often set personal and professional boundaries? ☐ Yes ☐ No

Do you currently, or have you ever, suffered from an addiction (i.e., porn, sex, gambling, drugs)? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

If yes, explain: _____

_____

Do you ever have suicidal thoughts? ☐ Yes ☐ No

Do you tend to react emotionally or logically? ☐ Emotionally ☐ Logically

Are you willing to address past trauma? ☐ Yes ☐ No

Do you tend to freely forgive others, or hold grudges? ☐ Freely Forgive ☐ Hold Grudges

How do you tend to approach problems/difficult situations? _____

_____

Do you have trouble giving someone else control? ☐ Yes ☐ No

How easily do you adapt to new and unfamiliar situations? ☐ Very easily ☐ Somewhat easily ☐ Not at all

What motivates you? _____

_____

Do you ever feel unmotivated? If so, when? _____

_____

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

Do you feel confident and secure about your sexual orientation, or are you questioning/unsure? _____

_____

How would you describe your childhood? _____

_____

_____

STRESS

Have you ever sought counseling or therapy? ☐ Yes ☐ No

Are you currently in counseling or therapy? ☐ Yes ☐ No

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily Stressors: Rate on scale 1-10. (1 - minimal stress. 10 - very high stress)

☐ Work ☐ Family ☐ Social ☐ Finances ☐ Health ☐ Other

What is your #1 stressor currently? _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No

If yes, circle all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathwork ☐ Tai Chi Prayer ☐ Other

Do you feel that you are capable of controlling your stress levels or response to stress? ☐ Yes ☐ No

How often to you practice meditation or relaxation techniques? ☐ Yes ☐ No

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

Do you participate in activities or have hobbies? If so, please describe the activity and the frequency.

Describe your energy levels throughout the day.

What are your resources for emotional support (spouse, pets, church, etc.)?

SLEEP & REST

Average number of hours you sleep per night ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have trouble falling asleep? ☐ Yes ☐ No
Do you feel rested upon awakening? ☐ Yes ☐ No
Do you have new areas of pain/soreness upon awakening? ☐ Yes ☐ No
Do you have problems with insomnia? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you use sleeping aids? ☐ Yes ☐ No
If yes, what and how often?

What time do you go to bed?
What time do you wake up?

ROLES & RELATIONSHIPS

CHILDREN		
Child's Name	Age	Gender

Who is living in your household? Names, relationships, and ages: _____

_____

_____

Their Occupation(s): _____

HOW WELL HAVE THINGS BEEN GOING FOR YOU?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

Are you satisfied with your sex life? _____

If not, what do you wish was different? _____

_____

_____

Other significant relationships, including friendships: _____

In a typical week, how often do you socialize with friends? _____

Do you feel that you can be vulnerable with friends? ☐ Yes ☐ No

Do you feel that you can depend on your friends? ☐ Yes ☐ No

Do you often vent to your friends? ☐ Yes ☐ No

Are you satisfied with the strength and size of your support system? ☐ Yes ☐ No

SPIRITUALITY ASSESSMENT

Do you feel like you are heard on a regular basis? ☐Yes ☐No
Do you feel that others see you, or simply look past you?
Do you feel like you matter in the lives of others? ☐ Yes ☐ No
Do you ascribe to any religious beliefs? ☐ Yes ☐ No
If yes, what are they? _____
Are you a part of a spiritual community? ☐ Yes ☐ No
If so, what is it? _____
Do you believe in a higher power? ☐ Yes ☐ No
If yes, do you feel personally connected to or alienated from this higher power? _____
_____
Have you ever had a profound experience that either hindered or promoted your spirituality? ☐ Yes ☐ No
Do you practice personal spirituality? ☐ Yes ☐ No
If so, how often? _____
Are you satisfied with your current depth and breadth of connections to others? ☐ Yes ☐ No
Do you often feel lonely? ☐ Yes ☐ No
Do you value yourself? ☐Yes ☐No
Are you your own best friend? ☐Yes ☐No
Do you talk to yourself in the same way you would talk to a friend? ☐ Yes ☐ No
Are you overly critical of yourself? ☐ Yes ☐ No
What do you love most about yourself? _____
What is the opposite of the thing you love most about yourself? _____
Do you feel as though you struggle in this area? _____
What do you dislike or judge most about other people? _____
Are you overly critical of others? ☐ Yes ☐ No
What traits are you attracted to most in other people? _____
How does that trait manifest in yourself? _____
Do you participate in volunteer or service activities? ☐ Yes ☐ No
If so, how often? _____
Do you regularly spend time in nature? ☐ Yes ☐ No
If so, how often? _____
How do you feel when you are in nature? _____
Do you feel connected to/grounded in your daily surroundings? ☐ Yes ☐ No
What gives you peace? _____
Have you ever experienced feelings of bitterness, guilt, anger, or resentment? ☐ Yes ☐ No
If so, how did you handle those feelings? _____
Whom do you need to forgive and for what? _____
_____
_____

PERSONAL STRESS INVENTORY (Include past and present events)

LIFE EVENT	POINTS	POINT TOTAL
Death of spouse	100	
Divorce	73	
Marital Separation	65	
Detention in jail or other institution	63	
Death of a close family member	63	
Major personal injury or illness	53	
Marriage	50	
Being tired from work	47	
Marital reconciliation	45	
Retirement from work	45	
Major change in health or behavior of a family member	44	
Pregnancy	40	
Sexual Difficulties	39	
Gaining a new family member (birth, adoption, older adult moving in, etc.)	39	
Major Business readjustment	39	
Major change in financial state (a lot worse or better off than usual)	38	
Death of a close friend	37	
Changing to a different line of work	36	
Major change in number of arguments with spouse on core issues	35	
Taking on a mortgage (for home, business, etc.)	31	
Foreclosure on a mortgage or loan	30	
Major change in responsibilities at work (promotion, demotion, etc.)	29	
Son or daughter leaving home (marriage, college, etc.)	29	
Conflict or tension with parents/in laws	29	
Outstanding personal achievement	28	
Spouse beginning or ceasing work outside the home	26	
Beginning or completing formal schooling	26	
Major change in living condition (new home, remodeling, deterioration of home)	25	
Change of personal habits (dress, manners, association, quitting, smoking)	24	
Conflict at work with employer or manager	23	
Major changes in working hours or conditions	20	
Changes in residence	20	
Changing to a new school	20	
Major change in usual type/or amount of recreation	19	
Major change in church activity (a lot more or less than usual)	19	
Major change in social activities (clubs, movies, visiting, etc.)	18	
Taking on a loan (car, TV, appliances, etc..)	17	
Major change in sleeping habits (a lot more or less than usual)	16	
Major change in number of family get-togethers	15	
Major change in eating habits (food amount, meal hours or surrounding)	15	
Vacation	13	
Major holidays	12	
Minor violations of the law (traffic, tickets, etc.)	11	
Your Total		

READINESS ASSESSMENT

Rate on a scale of: 5 (Very willing) to 1 (Not willing)

IN ORDER TO IMPROVE YOUR HEALTH, HOW WILLING ARE YOU TO:	5	4	3	2	1
Significantly modify your diet					
Take nutritional supplements every day					
Keep a journal of everything you eat each day					
Modify your lifestyle (e.g. work demands, sleep habits, etc.)					
Practice relaxation techniques regularly					
Engage in regular exercise					

Comments: _____

_____

_____

_____

LIFESTYLE CHANGE ASSESSMENT

Have you recently attempted to make a lifestyle change? ☐ Yes ☐ No

If so, what was it? _____

What was the greater purpose of this lifestyle change? _____

What motivated you to make this change/how did you decide to do this? _____

_____

How did you approach this lifestyle change (i.e., what did you do to accomplish this)? _____

Did you turn to others for advice and support? ☐ Yes ☐ No

Did you do any research to help with this lifestyle change? ☐ Yes ☐ No

How successful were you in implementing this lifestyle change?

☐ Not successful ☐ Somewhat successful ☐ Very successful

Looking back, what would you do differently? _____

_____

How has this lifestyle change affected your health/life? _____

_____

_____

In your opinion, how important is lifestyle change in achieving health/wellness?

☐ Not important ☐ Somewhat important ☐ Very important

Are you willing to make personal sacrifices to implement lifestyle changes? ☐ Yes ☐ No

Identify a healthy lifestyle change you would like to make. _____

_____

_____

List at least three motivating factors for making this lifestyle change.

List your priorities in order of importance.

How does the lifestyle change you have identified fit in with these priorities?

On a scale of 0 to 10, how confident are you that you can successfully implement this change? _____

Why have you chosen this level? _____

What factors would help to raise this confidence level? _____

THANK YOU

Thank you for taking the time to complete this Health Assessment Intake Form, providing in-depth information on your health, lifestyle, and goals.

The time and effort your invested is to be applauded! Your work here will help our work together to be much more informative and transformative!