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**PERSONAL WELLNESS ASSESSMENT**

*The information presented in this form is intended to help provide a profile of your past and present*

*nutritional health. Please fill out completely to the best of your knowledge. We will review this form in your consultation.*

**Personal Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_ Male\_\_\_ Female\_\_\_

Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_ft\_\_\_\_in

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_lbs

Current Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cholesterol\_\_\_\_\_\_ Date of test\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Date of test\_\_\_\_\_\_\_\_\_\_\_\_

Who were you referred by? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your health concerns and how long have they been an issue? Please give as many details as possible.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What medications, medical procedures, supplements or therapies have you previously tried for your condition? Which were helpful and which were not effective?

Please list: Helpful / Ineffective

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_

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On a scale of 1-10, how important is your health to you? *Scale is: 1=low, 10=highest importance*

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, how willing are you to make lifestyle changes to gain greater health?

*Scale is: 1=I don't want to change anything, 5=I will make moderate changes, 10=I will do anything it takes!*

1 2 3 4 5 6 7 8 9 10

If you are under a doctor's care for any conditions, please list them along with any medications or therapies you are using:

Medical Condition Medications or therapies

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate any surgeries, accidents or other trauma you have had in the past:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What nutritional supplements are you currently taking?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Lifestyle Practices**

**Diet**

1. Please list the foods you commonly eat for each meal. Don't worry about looking good here...we will start where you are at and move from there. It is helpful to get a realistic look at your day.

Breakfast (typical time eaten:\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Lunch (typical time eaten:\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dinner (typical time eaten:\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Snack (typical time eaten:\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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1. What types of food do you eat most often? \_\_fresh \_\_canned \_\_fast food \_\_frozen \_\_fried
2. How often do you eat the following foods: *1= once or more daily, 2= weekly, 3= occasionally, 4=never*

\_\_artificial sweeteners \_\_lunch meats \_\_dairy \_\_breads, crackers, pasta, etc.

\_\_fresh fruits \_\_red meat \_\_white meat \_\_fish, seafood

\_\_fresh vegetables \_\_eggs \_\_dessert \_\_candy bars, candy, etc.

1. List any foods you are allergic to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Check the statements(s) that best describe(s) your typical eating experience:

\_\_I eat quickly and often do not chew my food thoroughly. \_\_I chew my food slowly and relax.

\_\_I eat most meals while standing, driving or attending to other matters. \_\_I don't eat 3 meals per day.

1. Check the word(s) that best describe(s) your experience 30-60 minutes after eating:

\_\_bloated \_\_gas \_\_diarrhea/cramping \_\_headache \_\_ tired \_\_congested \_\_burning sensation \_\_filled/satisfied \_\_itching/hives \_\_wheezing \_\_nausea/vomiting \_\_pain (location)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Most foods I eat cause me to feel: \_\_energized \_\_guilty \_\_sick \_\_tired \_\_uncomfortable
2. Which types of foods do you crave frequently?

\_\_salty \_\_sweet \_\_protein \_\_chocolate \_\_caffeine \_\_carbohydrates \_\_fried \_\_alcohol

1. Please complete this statement: No meal is complete without:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fluid Intake**

1. Describe the type of water that you drink most frequently:

\_\_fluoridated \_\_well \_\_cistern \_\_bottled \_\_distilled \_\_reverse-osmosis \_\_Kangan

1. Check the phrase that best describes your drinking water habits :

\_\_I drink water throughout the day. \_\_I rarely drink water because I am rarely thirsty.

\_\_I drink water infrequently. \_\_I drink water frequently because I am always thirsty.

1. Approximately how many glasses (8 oz.) of water do you drink daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Check the type(s) of beverages you drink daily in addition to water:

\_\_coffee \_\_juice \_\_diet drinks \_\_tea (hot/cold) \_\_milk \_\_soda \_\_sports drinks \_\_non-dairy \_\_ caffeinated

1. How many ounces of the above beverages do you consume daily?\_\_\_\_\_\_\_\_\_\_\_\_ Weekly?\_\_\_\_\_\_\_\_\_\_\_\_
2. How many alcoholic drinks do you consume each week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dieting**

1. Have you ever dieted? \_\_Yes \_\_No
2. Check the phrase the best describe(s) your dieting experiences:

\_\_I have dieted off and on my entire life. \_\_My diet programs have been successful.

\_\_I lose a few pounds only to gain them back.

1. When you gain weight, in what area(s) do you generally notice it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise**

1. How often do you exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many minutes do you exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What do you do for exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Body Systems**

*Please check all that apply.*

**Respiratory/Sinus /13**

\_\_allergies

\_\_asthma or wheezing

\_\_sore throat frequently

\_\_sinus infections

\_\_frequent cough

\_\_bronchial infections

\_\_phlegm in throat

\_\_food sensitivities

\_\_constipation/diarrhea

\_\_congested air passages

\_\_itchy nose/ears

\_\_sinus headaches/congestion

\_\_swollen lymph glands

**Liver/Gallbladder /13**

\_\_pain between should blades

\_\_history of gallstones

\_\_crave fatty or greasy foods

\_\_frequent skin rashes

\_\_stools light-colored or float

\_\_bad breath (halitosis) or body odor

\_\_abdominal pain/discomfort

\_\_difficulty getting to sleep

\_\_fatigue or low energy

\_\_food allergies

\_\_constipation/diarrhea

\_\_headaches/migraines

\_\_varicose veins

**Structural /12**

\_\_joint stiffness upon arising

\_\_brittle bones or fingernails

\_\_history of joint injuries

\_\_muscle cramps at night

\_\_osteoporosis

\_\_joint pain, arthritis or gout

\_\_bulging/compressed disks

\_\_tendonitis/bursitis

\_\_feet hurt in the morning

\_\_dry skin

\_\_frequent backaches

\_\_weak legs, knees or ankles

**Intestinal /13**

\_\_abdominal pain/discomfort

\_\_bad breath or body odor

\_\_colitis or crohns

\_\_constipation or dry stool

\_\_excess mucus production

\_\_fatigue or low energy

\_\_intestinal gas or bloating

\_\_loose stools or diarrhea

\_\_muddled thinking, confusion, mental sluggishness

\_\_sinus congestion

\_\_headaches

\_\_swollen lymph glands

\_\_irritable bowel syndrome

**Digestion /13**

\_\_poor/excessive appetite

\_\_pale complexion or anemia

\_\_strong thirst

\_\_nausea/vomiting

\_\_acid reflux/heartburn

\_\_ulcers

\_\_gas/bloating

\_\_diarrhea/constipation

\_\_abdominal pain/discomfort

\_\_anxiety, nervousness, tension

\_\_cravings for sugar

\_\_food allergies

\_\_food sits heavy on stomach after eating

\_\_general weakness or chronic illness

**Urinary /13**

\_\_burning/painful urination

\_\_dark circles or puffiness under eyes

\_\_frequent backache

\_\_frequent urinary tract infections

\_\_elevated blood pressure

\_\_scant/excessive urination

\_\_incontinence

\_\_joint pain, arthritis, gout

\_\_kidney stones

\_\_osteoporosis

\_\_water retention

\_\_weak legs, knees or ankles

**Immune /13**

\_\_antibiotic use in the last year

\_\_frequent stuffy/runny nose

\_\_chronic fatigue or low energy

\_\_craving sweets or chocolate

\_\_bronchial infections

\_\_skin problems

\_\_nail fungus

\_\_muscular soreness

\_\_food allergies

\_\_frequent infections

\_\_general weakness or chronic illness

\_\_itchy nose/ears

\_\_swollen lymph glands

**Cardiovascular /13**

\_\_high/low blood pressure

\_\_irregular heartbeat

\_\_heavy or difficult breathing

\_\_bruise easily

\_\_dizziness/light headedness

\_\_swollen ankles

\_\_ringing/pounding in ears

\_\_varicose veins

\_\_numbness or coldness in hands or feet

\_\_craving fats

\_\_fatigue or low energy

\_\_diagnosis of any heart problems

\_\_wounds won't heal in extremities

**Stress/Anxiety/Depression /13**

\_\_apprehension/nervousness

\_\_depression/hopelessness

\_\_irritability

\_\_addictions

\_\_panic attacks or anxiety

\_\_inability to concentrate/forgetfulness

\_\_feeling overwhelmed

\_\_irritable bowel

\_\_difficulty going to sleep

\_\_fatigue or low energy

\_\_headaches/migraines

\_\_restless dreams or nightmares

\_\_waking up frequently at night

**Detoxification**

**Elimination History/Habits**

1. How many bowel movements do you have daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If bowel movements do not occur regularly, how many do you have weekly?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you have a history of diarrhea? \_\_Yes \_\_No Constipation? \_\_Yes \_\_No
4. Do you frequently have gas? \_\_Yes \_\_No
5. Does gas cause you pain, bloating, and discomfort? \_\_Yes \_\_No
6. Which words describe(s) your typical bowel movements?

\_\_loose and easy to pass \_\_hard and difficult to pass \_\_bloody \_\_floating \_\_frequently green

\_\_often black \_\_containing mucus \_\_frequent diarrhea \_\_preceded/followed by cramping or pain

1. Do you frequently have hemorrhoids? \_\_Yes \_\_No
2. Approximately how many times do you urinate daily?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Choose the word(s) that best describe(s) your urine:

\_\_contains blood \_\_looks like clear water \_\_has a strong odor \_\_contains particles or sediment

1. Choose the word(s) that best describe(s) your urination processes/habits:

\_\_cramping \_\_urgency \_\_easy and complete flow of urine \_\_burning/pain \_\_urinate frequently at night \_\_incontinence \_\_unable to empty bladder fully \_\_flank pain before/during/after

1. Do you have a history of urinary tract infections? \_\_Yes \_\_No
2. Which best describe(s) how your body sweats?

\_\_always \_\_occasionally \_\_only when I exercise \_\_when I am nervous \_\_rarely (even when it's hot outside)

1. Does your sweat have an unpleasant odor? \_\_Yes \_\_No
2. Do you regularly use a(n) \_\_antiperspirant \_\_deodorant?
3. Do you ever have any unexplained or unusual swelling, inflammation or fluid retention?

\_\_Yes \_\_No \_\_occasionally \_\_only premenstrual

1. If applicable, list area(s) of swelling/inflammation/fluid retention:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please check all that apply.*

**Parasites /14**

\_\_yeast infections

\_\_antibiotics in the past 5 years

\_\_nausea

\_\_indigestion, heartburn, GERD

\_\_joint & muscle pain

\_\_fatigue

\_\_frequent ear/nose/throat infections

\_\_auto-immune disease

\_\_rashes/hives/psoriasis/boils/acne

\_\_swelling in lymph nodes around neck

\_\_anemia

\_\_hypoglycemia (low blood sugar)

\_\_irritable bowel syndrome

\_\_diverticulitis/colitis/Crohns disease

\_\_I have lived on a tropical island

\_\_I have visited a foreign country in the past 5 years

**Environmental Chemicals /12**

\_\_I have \_\_\_\_\_\_(number) amalgam fillings.

\_\_I have \_\_\_\_\_\_(number) root canals.

\_\_New furniture or cabinetry in home or workplace

\_\_Home or workplace located close to excessive air, water or environmental pollution

\_\_Frequent exposed to toxic or poisonous materials

\_\_Home or workplace has recently been painted

\_\_Presently smoke or have smoked in the past

\_\_Frequently exposed to second-hand smoke

\_\_Have been exposed to radiation

\_\_Toothpaste contains flouride

\_\_History of drug addiction

\_\_Vaccinated as a child

**Viral /12**

\_\_frequent viral infections

\_\_recurrent canker sores

\_\_recurrent warts

\_\_history of polio

\_\_history of mononucleosis

\_\_Herpes Simplex I or Genital Herpes

\_\_history of infectious

\_\_Frequent cold or flu symptoms

\_\_frequent muscular aching/chills

\_\_frequent exposure to ill individuals

\_\_history of shingles (Herpes Zoster)

\_\_history of tonsillitis or croup

**Yeast/Fungal /14**

\_\_Indigestion after eating fruits & sweets

\_\_bloating after meals

\_\_chronic sinus problems

\_\_itchy skin/scalp

\_\_frequent antibiotic usage

\_\_cravings for sweets

\_\_cloudy thinking/mental fog

\_\_history of eczema/psoriasis/dandruff

\_\_constipation/diarrhea

\_\_consume a lot of sugar

\_\_vaginal discharge

\_\_recurrent urinary tract infection

\_\_allergy/sensitivity to the fermented/moldy

\_\_rectal burning or itching

**Heavy Metals /14**

\_\_metallic taste in mouth

\_\_loose teeth

\_\_chronic headaches

\_\_arthritis/pain in joints

\_\_mouth ulcers

\_\_swollen tongue

\_\_unexplained skin rashes

\_\_anxiety, depression

\_\_frequent exposure to fertilizers

\_\_frequent ingestions of seafood

\_\_tremors or twitching

\_\_autoimmune disease

\_\_bone loss around teeth

\_\_frequent exposure to lead-based paints/solvents/chemicals

**Bacterial /11**

\_\_frequent bacterial infections

\_\_chronic sinusitis

\_\_dental abscess

\_\_frequent exposure to ill individuals

\_\_history of staph or stress infections

\_\_frequent ear infections

\_\_sinus discomfort or facial bone pain

\_\_unusual skin rash/eczema

\_\_frequent discolored mucus/nasal secretions

\_\_history of tuberculosis

\_\_bitten by a deer tick

**Glandular System**

**Stress**

1. Are you under stress? \_\_Yes \_\_No If so, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. I respond to stress by: \_\_exploding \_\_lashing out \_\_holding it in \_\_becoming anxious or nervous \_\_eating
3. My daily stress level is: \_\_low \_\_moderate \_\_high \_\_very high \_\_I don't get stressed daily
4. How many hours of sleep do you get each night on average?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Which statement(s) best describe(s) your sleep? \_\_restless \_\_deep \_\_light \_\_hard to fall asleep

\_\_wake up frequently at night (how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ what time usually?\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. What is your energy level like? \_\_extremely high \_\_high \_\_moderate \_\_low \_\_extremely low

*Please check all that apply.*

**Adrenal /13**

\_\_cravings for salt/sweets

\_\_constant or chronic fatigue

\_\_headaches/migraines

\_\_low blood pressure

\_\_chronic back pain

\_\_panic attacks

\_\_nervousness

\_\_muscular weakness

\_\_extreme sensitivity to odors/noise

\_\_stress-filled lifestyle

\_\_clenching or grinding of teeth at night

\_\_blood sugar disturbances

\_\_tendency to gain weight in the waist (love handles)

**Thyroid /13**

\_\_cold hands and feet

\_\_dry/brittle hair

\_\_fatigue

\_\_tired in AM and energetic in PM

\_\_slow or slurred speech

\_\_muscle cramps, especially at night

\_\_frequently constipated

\_\_PMS or menstrual difficulties

\_\_hair loss

\_\_cracks in bottom of your heels

\_\_low libido

\_\_swelling of hands and face

\_\_low body temperature

**Blood Sugar /11**

\_\_eat when nervous

\_\_excessive appetite

\_\_hungry between meals

\_\_irritable before meals

\_\_get "shaky" if hungry

\_\_"lightheaded" if meals are delayed

\_\_heart palpitations if meals are missed

\_\_afternoon headaches

\_\_awaken after a few hours of sleep

\_\_crave sweets or coffee

\_\_afternoon fatigue

**Female ED/EL /11**

\_\_tender breasts

\_\_anxious/nervous feelings

\_\_weight gain in hip/waist area

\_\_menstrual bleeding changes

\_\_water retention

\_\_uterine fibroids

\_\_fibrocystic breasts

\_\_mood swings/irritability

\_\_cold body temperature

\_\_headaches

\_\_infertility

\_\_hot flashes **/11**

\_\_foggy thinking/memory lapses

\_\_heart palpitations

\_\_night sweats

\_\_bone loss

\_\_increase in facial/body hair

\_\_increased urinary urge/incontinence

\_\_vaginal dryness

\_\_trouble falling asleep or staying asleep

\_\_weight gain around waist

\_\_depression

**Pituitary/Hypothalamus /10**

\_\_failing memory

\_\_low blood pressure

\_\_increased sex drive

\_\_splitting headaches

\_\_decreased sugar tolerance

\_\_abnormal thirst

\_\_bloating of abdomen

\_\_tendency toward ulcers

\_\_weight around hips or waist

\_\_sugar cravings

**Male Health /10**

\_\_enlarged prostate

\_\_elevated PSA count

\_\_difficult or dribbling urination

\_\_lack of motivation/energy

\_\_depression

\_\_leg nervousness at night

\_\_diminished sex drive

\_\_erectile dysfunction

\_\_migrating aches and pains

\_\_feeling of incomplete bowel evacuation

**Informed Consent**

Thank you for allowing us to assist in your quest for good health. We understand that you have the opportunity to choose from a variety of health care practitioners, wellness philosophies and forms of analysis in your quest for optimal health. Having chosen our services, we will conscientiously work to do our best to help you achieve your wellness goals. It is also important that you understand who we are, what we believe and what we do.

**Who we are not:**

* We have no licensed physicians or surgeons on staff.
* We do not willfully diagnose or treat diseases or medical conditions, nor do we conduct surgery or perform any invasive bodily procedures.
* We do not prescribe or administer legend drugs or controlled substances to another person.
* We do not recommend discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner.

**Who we are:**

Our staff includes

* A Certified Natural Health Professional
* We are committed to continuing wellness education and training.

**What we believe about health:**

* God is the Creator of the universe, which includes all of mankind and foods designed to sustain us.
* God has established certain spiritual, physical and dietary laws in the universe that bring forth blessing when

followed and harm when they are not.

* Because of mans propensity to do what is wrong, God has provided His authoritative Word, the Bible, to instruct us in

truth and righteousness and contains many dietary and general health principles to help guide our decisions and practices

that will promote wellness.

* Modern science and complimentary/alternative health practices have done much to help man achieve better health, but must be adjusted to conform to God's Word regarding health.

I have read and understand the above disclosure. I have voluntarily submitted all the accompanying information, and have not been coerced in any manner. I acknowledge that I assume full responsibility for my choices regarding health care , wellness philosophies, and my decision to participate in any services, assessments or consultations provided by Balms and Manna. I do not hold Balms and Manna, or any associated employee or person, liable in any way for recommendations or suggestions made on mine, or my family's behalf. I understand that any information provided is intended for educational purposes only and is not to be used to diagnose, treat or cure any disease. I further understand that the primary emphasis of this establishment is on total wellness and good health practices, not on specific treatment of illness or disease. I am seeking education advice, and am not visiting on a mission of entrapment or as a representative of any state or local authority. *Note: If you have a serious health problem, please consult a competent health care practitioner.*

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Beloved, I wish above all things that thou mayest prosper and be in health, even as thy soul prospereth. ~ III John* 2

**Balms and Manna • 24479 E 800 N Rd Fairbury, IL 61739 • 330-466-1432**

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