

# The Health and Wellness Center

## New Client Application

Attention: To maximize your evaluation with the Health Coach, please fill out **all** paperwork prior to your office visit.

Please show up 20 minutes before your scheduled appointment.



Client Case Record

Name: \_\_\_\_\_ Date: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Spouse: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Gender: \_\_\_\_\_  
Occupation: \_\_\_\_\_ S.S.#: \_\_\_\_\_  
Who referred you? \_\_\_\_\_

Please list the five main important complaints in order of importance: \_\_\_\_\_ / \_\_\_\_\_

1. \_\_\_\_\_ When did it start? \_\_\_\_\_

Office Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intermittent / Constant  
Sharp / Dull / Achy  
Mild / Mod / Severe

2. \_\_\_\_\_ When did it start? \_\_\_\_\_

Office Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intermittent / Constant  
Sharp / Dull / Achy  
Mild / Mod / Severe

3. \_\_\_\_\_ When did it start? \_\_\_\_\_

Office Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intermittent / Constant  
Sharp / Dull / Achy  
Mild / Mod / Severe

4. \_\_\_\_\_ When did it start? \_\_\_\_\_

Office Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intermittent / Constant  
Sharp / Dull / Achy  
Mild / Mod / Severe

5. \_\_\_\_\_ When did it start? \_\_\_\_\_

Office Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intermittent / Constant  
Sharp / Dull / Achy  
Mild / Mod / Severe

Current Medications taking and what for: (client fills out)

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

Office Use – Additional Practitioner Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**History of illnesses, surgeries, removed organs and treatments:**

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**Allergies / Sensitivities: (list food and drug sensitivities / allergies)**

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**Health Ratings: Please rate how you currently are in the following areas on a scale of 0-10.**

Energy Level \_\_\_\_\_ (10 = Excellent)      Sleep Level \_\_\_\_\_ (10 = Excellent)      Stress Level \_\_\_\_\_ (10 = High)  
Digestion/Elimin. \_\_\_\_\_ (10 = Excellent)      Gen. Pain Level \_\_\_\_\_ (10=High)      Craving Level \_\_\_\_\_ (10 = High)

**List any health problems that your family members have or had: (father, mother, siblings)**

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**Current Physician Name / Address / Phone Number:**

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**Office Use - Practitioners Notes:**

HRT, Birth Control Pills - time: \_\_\_\_\_

History of stress events: \_\_\_\_\_

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Other notes: \_\_\_\_\_

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**Office Use - Evaluation Notes:**

Will: \_\_\_\_\_ / Commit: \_\_\_\_\_ / FBA: \_\_\_\_\_ / BP: Lay \_\_\_\_\_ Stand \_\_\_\_\_

Body Shape: \_\_\_\_\_ / UA: \_\_\_\_\_ / Resistance: \_\_\_\_\_ Reactance: \_\_\_\_\_

Motive: \_\_\_\_\_

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Practitioner or Health Coach Signature: \_\_\_\_\_

# Symptom Survey

Please Check Off all that Apply:

## Section 1

- Cravings for junk food
- Drinks wine in the evenings
- Craves refined carbohydrates
- Frustrating, stubborn weight
- History of low-calorie diets
- History of up and down weight
- Fluid retention
- \*History of birth control pills
- \*History of Hormone Replacemnt Therap
- High protein diets don't work
- Poor willpower
- Can't lose weight despite exercise
- History of blood sugar problems
- History of menstrual problems

## Section 2 (female only)

*Please fill out if you have ever had any*

- PMS
- Irregular periods
- Depression during menstruation
- Bloating & cramping during menstration
- Weight gain during menstruation
- Weight gain during ovulation
- Difficulty losing weight after pregnancy
- Heavy bleeding during menstruation
- Enlarged, swollen breasts during menstr.
- Hot flashes
- Night sweats
- Vaginal dryness
- Leaky bladder
- Frequent urination at night

## Section 3

- Out of breath when walking stairs
- Dizziness
- Excessive facial hair – female
- Perspiring after getting out of shower
- Fatigue during the day
- Difficulty getting out of bed in morning
- Waking up in the middle of the night
- Difficulty falling asleep

- Afternoon headaches
- Arthritis or stiff and painful joints
- Bursitis
- Tendonitis
- Twitch under eye lid
- Heel spurs
- Low back weakness or pain
- Itchiness or hives
- Nervousness
- Dehydrated despite fluid consumed
- Swollen ankles
- Cravings for salt (chips, pretzels)
- Enlarge abdomen
- Enlarged bump in upper back/lower neck
- Hands and feet go to sleep easily
- Chest pain
- Muscle cramps, worse during exercise
- Dull pain in chest or radiating in left arm

## ADDITIONAL NOTES:

*\*List approx dates and length of time on HRT or Birth Control*

--OVER--

