Client Information Sheet

Name: _____
Date of Birth:_____ **Age:** _____ **Gender:**_____
Address:

_____

_____

Cell Phone:_____
Email: _____
With Whom may we discuss your scans?

_____
Who referred you?/How did you find us?

_____

Please list below your four main health complaints in order of importance. Then rate them on a scale from 1 to 10, with 1 being very little impact on you and 10 being greatly impacted.

1._____
2._____
3._____
4._____

Nutritional data:
How many ounces of water/day? _____ What kind?_____
What other beverages and how much?

_____
Do you use artificial sweeteners? _____ If so, which ones?_____
How often and in what?

_____
Do you eat breakfast? _____
If so, what?

_____

How much of the following do you consume?
(example: 1D = 1/day, 2W = 2/week, 3M = 3/month)

Fruit _____ Vegetables _____ Eggs _____ Dairy _____ Fermented food _____
Fast food _____ Chicken _____ Fish _____ Red Meat _____ Pork _____
Meat Alternatives _____

What do you crave? _____
What foods do you dislike the most?

_____
Why?

_____

_____

Timing:
What is the first thing you do when you get up in the morning?

_____

What time do you eat your first meal? _____ Last meal? _____
Which meal is your largest of the day?

_____
Describe a typical largest meal.

_____

_____

Movement:
Do you exercise/move/participate in fun, sweaty activity? If so, what and how often?

_____

_____

_____
Do you look forward to it?

_____
How do you feel when you are finished?

_____

Sleep:
What time do you go to bed? _____ How long do you sleep? _____
Do you wake often? _____
If so, why and at what time(s)?

_____
Do you feel rested when you wake up for the day?

_____
Do you have pain when you first get up? _____
If so, where?

_____

_____
Does it go away upon moving?

_____

Females:

Are you postmenopausal? _____

If yes, at what age did you enter menopause? _____

What were the characteristics of your menopausal experience?

_____

_____

Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? _____

Are you now, or in the near future, planning to become pregnant?

_____

Are you breastfeeding?

_____

Is your menstrual cycle regular? _____ Longer than 28 days? _____

Shorter? _____

Is your flow longer or shorter than 5 days?

_____

Do you have cramps or clotting? _____

Would you describe the color of your menses as bright red, dark purple, or brown?

_____

Do you experience PMS, cyclical headaches, or cravings?

_____

_____

Eliminations:

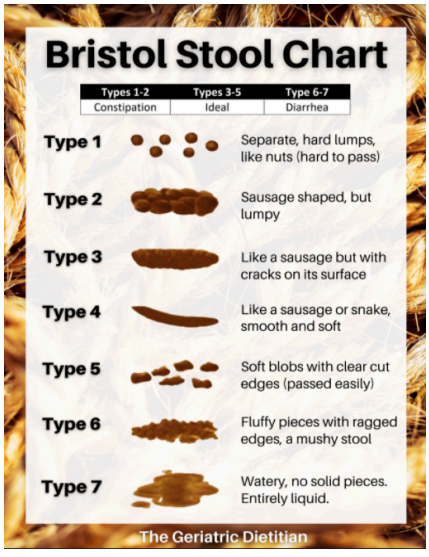
Do you have daily bowel eliminations? _____ If yes, how many per day? _____

If no, please describe your elimination pattern.

_____

_____

Please indicate the most descriptive number(s) of your elimination(s) using the Bristol Stool chart provided. BSC # _____ Color _____



Children Only
Weight: _____ (lbs)

Supplements/Medications:
Do you take any supplements? _____ If so, what, how often and why?
**** The body needs the right tools at the right time to heal. Testing is always better than guessing, so I recommend sending a sample of any supplement you'd like to continue taking while doing RW's recommendations to ensure your products are helpful at this time. I will gladly test your supplements first before recommending new ones. Please include these with your samples when you mail them.**

_____
_____
_____
_____
_____
_____

Do you take any **OTC medications** routinely (such pain reliever or allergy medicine)? If so, what and how often?

_____
_____
_____
_____
_____

Do you take **prescription medications** (prescribed by a licensed medical professional?) **If so, what and how often?**

_____
_____
_____
_____
_____
_____

Medical History:

Have you had any surgeries? If so, what and when?

_____
_____
_____
_____

Have you received any **diagnoses** from licensed medical professionals? If so, what and when? _____

_____
_____
_____
_____
_____

Do you have a pacemaker? _____

Do you have any **allergies**? _____ If yes, to what and what are the reactions?

_____
_____
_____
_____

Dental: Do you have-

Root Canal(s)? _____ Implant(s)? _____

Amalgam (silver colored) Filling(s)? _____

Dental surgery history?

_____
_____
_____

Other significant past accidents or injuries?

_____
_____
_____

List any other family history or illness/disease.

_____
_____
_____
_____
_____
_____

I understand that I am here to learn about nutrition and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purposes or treatment procedures. I understand that Reclaiming Wellness LLC adopts a Christian worldview as set forth in the Bible. I am not on this visit, or any subsequent visit, an agent for federal, state or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature :_____Date: _____

Guardian Signature: _____

(if under 18 years of age)

Relationship:_____