Initial Health and Wellness Consultation

Name _____ Date: _____
Height: _____ Weight: _____ Age: _____
Chief Complaint:_____
_____
Wellness Goals: _____
_____
Digestion: _____
_____
Elimination: _____
_____
Sleeping Habits: _____
_____
Energy Level: (*1 "Low" to 10 "High")* _____
_____
OTC/ Prescribed Medications: _____
_____
Surgeries: _____
_____
Toxic Burden Index: _____

Examination:

Blood Pressure (Rag land's test):
Lying: _____ /_____ Sitting: _____ /____ Standing: ____ /_____
Body Fat %: _____ BMI_____

Conclusions and Plan: _____
_____
_____
_____

Recommended Program for Optimal Success:

□ Detoxification/Weight Loss: ____Weeks/Months
□ Candida/Weight Loss: ____Weeks/Months
□ Hormone Balancing/Weight Loss: ____Weeks/Months
□ Rejuvenation/Weight Loss: ____Weeks/Months
□ Fibromyalgia/Weight Loss: ____Weeks/Months
□ Other _____

□ Maintenance of Weight Loss: ____Weeks/Months