

Date: _____

QBPOS: Log
Email: File Call Referred By: _____

Name: _____ Sex: M / F Date of Birth: _____ Age: _____

Phone: Main #: _____

Address: _____

Cell: _____

City: _____ Zip: _____

How did you hear about us? _____ **Email:** _____

Is this a Full Comprehensive Consultation (fees apply) or a 10 minute Complimentary Consult? Full Consult Complimentary Consult

What are your reasons for coming in today? Main Health Concerns and Health Goals (Please List)?

1. _____ 2. _____ 3. _____

Put a check next to your daily habits:

- | | | |
|--|---|--|
| <input type="checkbox"/> Skip meals | <input type="checkbox"/> Drug Use/Recreational Drugs | <input type="checkbox"/> Sleep Hours/Day: _____ |
| <input type="checkbox"/> Eat too much/too fast | <input type="checkbox"/> Constant Snacking | <input type="checkbox"/> Exercise/Week: _____ |
| <input type="checkbox"/> Addicted to carbs | <input type="checkbox"/> Smoke/Past Smoker # _____ | <input type="checkbox"/> T.V hours/Day _____ |
| <input type="checkbox"/> Eat junk food/fast food | <input type="checkbox"/> Strong cravings (sweet/salt/fat) | <input type="checkbox"/> Daily Stress: 1 2 3 4 5(high) |
| <input type="checkbox"/> Eat out # wk _____ | <input type="checkbox"/> Not enough water # _____ | |
| <input type="checkbox"/> Emotional eating | <input type="checkbox"/> Energy: 1 2 3 4 5(best) | |
| <input type="checkbox"/> Drink alcohol # _____ | <input type="checkbox"/> Caffeine Intake: _____ | |

Do you have any health issues?

- | | | |
|---|---|--|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Cold/Flu/Immune System | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Migraines/Head Aches | _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Allergies/Sensitivities |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gas/Bloating | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation or Diarrhea | <input type="checkbox"/> Meds/Supplements |
| <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Menopause/Hormonal Imbalance | <input type="checkbox"/> Mental Illness/Health | _____ |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Weight Problem-Over/Under Weight | <input type="checkbox"/> Osteoporosis | |

Diet/Food List (list foods you eat for each meal) Are you vegetarian: Yes / No **Blood Type:** _____

Breakfast: _____ Lunch: _____ Dinner: _____ Snacks: _____ Drinks: _____

What is your motivation for your overall health and well-being?

What are you looking for with your health, a quick fix, or looking for optimal health and wellness?

- Short term goal, Quick Fix
- Prescription for Life, Optimal Health

Are you ready to follow a structured program? (circle) Yes / No

FAMILY HISTORY (List any known health problems of family members.)

PAST MEDICAL HISTORY (list any past hospitalizations, surgeries, illnesses, immunizations)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I have read the Notice of the Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I was informed that I may also obtain a copy of the Notice from your receptionist. I hereby acknowledge that I reviewed from the Natural Wellness Center a copy of the Notice.

CONSENT FOR CONSULTATION

I, the undersigned, hereby authorize Natural Wellness Center (NWC), (and/or any associate or assistant involved in my care) to treat my condition(s), and fully understand that there is no promise or stated guarantee has been made as to result or cure; and I will not hold NWC and its staff responsible for my individual results of services that I have requested. I certify that the information I have reported with regard to my confidential patient fact sheet. **If patient is a minor**, unable to sign or incompetent to give consent, relationship of person authorized to give consent must be noted.

Print Your Name _____ Your Signature _____ Date _____

Name of Parent or Guardian _____ Your Signature _____ Relationship _____ Date _____