The Nutrition and Wellness Center

Name _____Age___ Date_____

Street Address _____City_____ State_____ Zip Code_____

Cell phone_____ Other phone_____ Sex_____ Blood type____

Height_____ Weight _____ Date of Birth _____ Marital Status_____ No. of Children _____

Email address: _____Occupation _____

Who may we thank for referring you? _____ Opt: Faith/Religion_____

Circle reason(s) for office visit: Allergy Assessment Bio Energetic Assessment Colon Hydrotherapy

Dental Assessment Ionic Foot Cleanse Infrared Sauna Nutritional Assessment Weight Loss

Purification/Detox Program Light Therapy Encouragement

List current health problems for which you are being treated:_____

_____

_____

_____

Current medications, prescriptions or over-the-counter drugs:

Drug Name	Reason for taking	Drug Name	Reason for taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Major hospitalizations, surgeries, injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, illness or injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest) 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (e.g. changes in job, work, residence or finances, legal problems)

_____

Do you consider yourself ____Underweight ____Overweight ____Just right My goal weight is _____

Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. fireman, etc.)? _____

What are your current health goals: _____

_____

_____

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Name: _____ Date: _____

Rate each of the following areas based on your symptoms in past month on a scale of 0-4:
0: Never or almost never --- 4: Frequently and severely

Head
____ Headaches
____ Faintness
____ Dizziness

____ **TOTAL**

Nose
____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucus
____ **TOTAL**

Lungs
____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing
____ **TOTAL**

Energy/Activity
____ Fatigue, sluggish
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness
____ Insomnia
____ **TOTAL**

Emotions
____ Mood swings
____ Anxiety, fear
____ Anger, irritability, aggressiveness
____ Depression
____ Tearful
____ **TOTAL**

Eyes
____ Watery or itchy eyes
____ Swollen, reddened or sticky eyelid
____ Bags or dark circles under eyes
____ Blurred vision
____ **TOTAL**

Reason for visit today:

Mouth/Throat
____ Chronic coughing
____ Gagging, frequent need to clear throat
____ Sore throat, loss of voice, hoarseness
____ Canker sores
____ **TOTAL**

Heart
____ Irregular or skipped heartbeat
____ Rapid or pounding heartbeat
____ Chest pain
____ **TOTAL**

Joint/Muscle
____ Pain in joints
____ Arthritis
____ Stiffness
____ Aches in muscles
____ Bone loss
____ Weakness or tiredness
____ **TOTAL**

Mind
____ Poor memory
____ Confusion, poor concentration
____ Poor physical coordination
____ Difficulty with making decisions/foggy thinking
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities
____ **TOTAL**

Ears
____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing in ears
____ Loss of hearing
____ **TOTAL**

Skin
____ Acne
____ Hives or rashes
____ Dry skin
____ Hair loss
____ Flushing or hot flashes
____ Excessive sweating
____ Easy bruising
____ Increased facial/body hair
____ **TOTAL**

Digestive Tract
____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloating, belching
____ Passing gas
____ Heartburn
____ Intestinal/stomach pain
____ Poor appetite
____ Bloody stools
____ Liver or gallbladder trouble
____ **TOTAL**

Genito-Urinary
____ Frequent urination
____ Painful urination
____ Blood in urine
____ Inability to control urine
____ Kidney stones
____ Prostate trouble
____ **TOTAL**

Weight
____ Craving certain foods
____ Compulsive eating
____ Cold body temperature
____ Water retention
____ Recent weight gain
____ Recent weight loss
____ **TOTAL**

Other
____ Numbness in _____
____ Swelling of ankles
____ Frequent illness
____ Sensitive to chemicals
____ **TOTAL**

GRAND TOTAL: _____

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Check all that apply:

Medical (Men)
__Enlarged prostate
__Prostate cancer
__Decreased sex drive
__Infertility
__Sexually transmitted disease
Other_____

Medical (Women)
__Menstrual irregularities
__Breast tenderness
__Endometriosis
__Infertility
__Fibrocystic breasts
__Ovarian fibroids or cysts
__Uterine Fibroids
__Premenstrual Syndrome (PMS)
__Breast cancer
__Vaginal infections
__Vaginal dryness
__Decreased sex drive
__Sexually transmitted disease
__Menopause
Other_____

__ # of pregnancies
__Age of first period
Date of last menstrual cycle_____
Typical menstrual cycle____days
Length of flow ____days
Any recent changes in menstrual flow (i.e. heavier, lighter) _____

Exercise
__1-2 days per week
__3-4 days per week
__5-7 days per week
__Less than 30 minutes
__30 minutes
__60 minutes
__Walk
__Run, jog, other aerobic
__Weights/strength training
__Stretching
__Yoga
Other_____

Additional Therapies
_____ Acupuncture
_____ Chiropractic
_____ Colonics
_____ Massage
Other_____

Health Habits
_____ Cigarettes/day
_____ Cigars/day
_____ Wine glasses/day
_____ Liquor ounces/day
_____ Beer glasses/day
_____ Coffee cups/day
_____ Tea cups/day
_____ Soda/day
_____ Diet soda/day
_____ Water glasses/day

Eating Habits
__Eat one meal/day
__Eat two meals/day
__Eat three meals/day
__Graze (small, frequent meals)
__Generally, eat on the run
__Eat constantly whether hungry or not
__Skip meals – which ones_____
__Juice – how often
_____

Nutrition and Diet
__Balanced diet (animal and vegetable sources)
__Vegetarian
__Vegan
__Salt restriction
__High protein/low carb.
__Dairy free
__Wheat free
__Egg free
__Soy free
__Gluten free
__Corn free
Other_____

Current Supplements
__Amino acids
__Antioxidants (turmeric,etc)
__Calcium
__CoQ10
__Digestive enzymes
__EPA/DHA
__Herbs
__Homeopathics
__Magnesium
__Multivitamin/mineral
__Probiotics
__Vitamin C
__Vitamin D3
__Vitamin E
__Zinc
Others_____

Making Lifestyle Changes
__I am comfortable and willing to make diet and lifestyle changes immediately
__I am not as comfortable making diet and lifestyle changes and prefer to make small changes initially
__I have taken supplements before and am comfortable taking a variety of items daily
__I have not taken supplements before but am open to starting
__I am willing and able to invest what is needed per month to achieve optimal health
__I am not ready for supplements

I Would Like To(check off):

(Energy & Vitality)
__Have more energy
__Have more endurance
__Be less tired
__Sleep better
__Be free of pain
__Get fewer colds and flu
__Get rid of allergies
__Not be dependent on medications
__Stop using laxatives and stool softeners
__Improve sex drive
(Stress)
__Learn how to reduce stress
__Think more clearly and be more focused
__Improve memory
__Be less depressed
__Be less moody
__Be less indecisive
__Feel more motivated
(Life Enrichment)
__Reduce my risk of degenerative disease
__Age gracefully
__Maintain health
__Change from “treating disease” to creating a healthy lifestyle
Other_____

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TWO DAY ACTIVITY SHEET

Please thoroughly complete the diet and activity chart below. Provide as much detail as possible, including quantity/serving sizes and whether food is cooked or raw.

	Day 1	Day 2
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (cups)		
Fats & Oils used		
Condiments		
Type of exercise		
Duration of exercise		
Sleep (Hours)		
Time to bed		
Time for Relaxation		

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INFORMED CONSENT FORM

The Nutrition and Wellness Center does not do any of the following things, either implied or intended:

1. We do not diagnose.
2. We make no attempt to cure any condition.
3. We make no claims or imply any claims that suggestions and/or opinions are given to cure any condition.
4. We do not claim that any supplemental material we may speak about will cure any condition, or that its' purpose is to treat any condition.
5. We do not prescribe or treat disease; however, we do attempt to educate you in/on dietary recommendations and exercise if it is not contradictory to the recommendations of your primary physician.

I, the undersigned client, understand the above statements. All decisions relative to my well-being and health must be made by me. I further understand that The Nutrition and Wellness Center staff are not medical doctors and are not attempting to portray them self or conduct the activities of medical doctors. Whether I participate in the programs and therapies provided at The Nutrition and Wellness Center is my decision based on my God given inalienable rights and my constitutionally guaranteed rights secured by the Bill of Rights. It is my creator-endowed inalienable right to ask for assistance of my own choosing and I accept full responsibility.

(For adults using the RJL Bio-Impedance device for body composition and the BioEnergetic Assessment/Bio Meridian: I am not pregnant. I do not have an implanted electrical device. I understand that I will be using a galvanic skin response measurement device to collect bioelectrical impedance measurements. I understand these devices are not intended to diagnose and are not to be a replacement for seeking medical attention.)

Cancellation Policy: We have a 48 hour cancellation and/or rescheduling policy. Cancellations less than 48 hours in advance of the appointment time, will have a 50% fee of appointment cost applied to account. Please call (757)221-7074 or email info@tnawc.com to cancel or reschedule.

PRINTED NAME: _____

Signature: _____ Date: _____

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- Welcome to The Nutrition and Wellness Center. We appreciate the confidence and trust you have placed in our clinical and nutritional expertise. Our utmost commitment is to see that you achieve your health goals in the most efficient manner possible. We are a team that is committed to excellence in serving and supporting you in the process of achieving optimal health.
- Complete the client forms attached and bring to your appointment. We require that you complete the forms prior to your appointment so that the entire duration of your appointment can be dedicated to health evaluation and consultation. If forms are not completed prior, please arrive 15 min early.

Your Initial Consultation may include (any or all of) the following depending on scheduled appointment time:

- Evaluation of your health
  - Check weight
  - Functional testing
    - ***Bio-Impedance Analysis** – A fluid analysis to identify measurements of resistance and reactance to determine cellular health, energy storage capacity due to intact cellular membrane integrity, resting metabolic rate of calories burned in 24 hours, body fat percentage and pounds, lean mass percentage and pounds, and intracellular and extracellular distribution of your total body water. One of the earliest signs of failing health is a shift of fluid from intracellular to extracellular, indicating possible toxicity.
    - **Ragland's Test** – An analysis of your blood pressure when standing and lying down to determine the level of adrenal health and function, which is associated with your ability to handle stress.
    - **Applied Kinesiology Assessment –** This is a kinesiology technique designed to access the energetic anatomy of the body via specific anatomical points (acupuncture points/meridians) using a muscle response. This assessment uses sensory input and motor output giving subjective data.
    - **Eye and Tongue Analysis** – An analysis looking at the physical markers of the eyes & tongue.
    - **BioEnergetic Assessment –** This BioMeridian scan accesses acupuncture meridians of the body and thereby gives a general picture of the energy flow through organs and structures located along those meridians. The assessment provides a means of measuring the energetic profiles of organs, glands, immune system, the musculoskeletal system and allergies. It is not diagnostic and gives objective data.
    - **Blood Work Review** – Not required but if available for initial, it may be reviewed and discussed.
- Individual consultation
  - Review Health History and address problem areas.
  - Discuss assessment results.
  - Establish health goals and commitment to reach them.
- Development of individualized plan for optimal health
  - **Individualized Supplement Plan** - A nutrition supplement plan may be developed to assist you with your bio-individual chemistry health needs identified during the evaluation of your functional test results and health history. Your supplement plan may include medical foods, vitamins, minerals, herbs, enzymes, amino acids, fatty acids, glandular therapy, homeopathy, essential oils and Bach Flower remedies.
  - **Personalized Menu Plan** - A menu plan will be developed based on your basal metabolic rate, blood type, health history, functional test results and/or activity level.
  - **Follow up appointments** – A follow up appointment and additional functional testing will be scheduled and determined based on your individual health needs and goals.

ONLY FOR APPOINTMENTS THAT INCLUDE the*Bio-Impedance Analysis

- Do not consume alcohol 24 hours prior to your appointment.
- Do not exercise 12 hours prior to your appointment.
- Do not eat for 3 hours before your appointment.
- Drink at least 2-3 glasses of water before your appointment.
- If possible, do not drink caffeine the day of your appointment.

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