Health & Wellness Analysis

Name: _____ Date: _____

Address: _____ City: _____ Zip Code: _____

Best Phone Number: _____ Email Address: _____

Date of Birth (month/day/year)_____ Age_____ Ht._____ Wt._____ Eye Color _____

Occupation: _____ Marital Status: (Circle one) Married - Single - Single Again – Widowed

Do you have children: _____Yes _____No If yes, please list their ages: _____

Emergency Contact Name: _____ Phone: _____

List current health challenge(s), in order of priority, and how long you've had the issue(s).

1._____ _____

2._____ _____

Please indicate the NUMBER of the following beverages you consume. Please note if consumed WEEKLY or DAILY.

Drink Type	# Daily or Weekly?		Drink Type	# Daily or Weekly?
Coffee - caffeinated			Cow's Milk	
Coffee - decaffeinated			Plant Based milk	
Tea – black/regular			Tap water	
Tea – Herbal/Green			Bottled water	
Soft drinks (caffeine)			Filtered Water	
Soft drinks (caffeine free)			Sports/Energy Drink	
Fruit Juice			Alcohol	

Do you use artificial sweeteners such as Splenda/sucralose or NutraSweet/aspartame? ☐ Yes ☐ No

On average, how many times a week do you dine out? _____

What foods do you crave? _____

Do you eat organic foods? ☐ Yes ☐ No If yes, what percent of total food intake is organic? _____

Do you avoid certain foods? If so, please list: _____

Do you consume raw fish/seafood (ie. sushi)? ☐ Yes ☐ No

Do you eat the recommended 7-13 servings of fruits and vegetables daily? ☐ Yes ☐ No

Food Allergies:_____

Other Allergies: _____

Do you currently smoke ☐ Yes ☐ No Did you smoke in the past? ☐ Yes ☐ No

How many years ago did you quit? _____ Does anyone in your home smoke? ☐ Yes ☐ No

Do you have tattoos and year(s) applied? ☐ Yes ☐ No _____

List all prescription medications you are currently using and note the medical condition they are for, including birth control and hormone replacement therapy? Attach additional page if necessary

Medication	Medical Condition

List all nutritional supplements you take and reason for taking. Attach additional page if necessary.

Supplement	Reason for taking

Self and Family Health History – List condition and indicate self and/or family member. Attach additional page if necessary

Health Condition	Self	Family Member	Age

Surgeries – Attach additional page if necessary

Surgery	Month/Year

How many bowel movements do you have per day? _____ If not daily, how many per week? _____

Circle any digestive issues you experience. Gas, Bloating, Acid reflux, Belching, Other:_____

On average, how many hours do you sleep per night? _____On average, what time do you go bed?_____

Do you sleep through the night? ____Y _____N If awakened, what time?_____

Rate your stress level on scale 1-10 (1=low, 10=high) _____Rate your energy level on scale 1-10 (1=low, 10=high)_____

Is weight loss or gain something you'd like to experience? ☐ Yes ☐ No If YES, How many pounds _____?

On average, how much do you exercise? Check box below

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

What modalities are you <u>using currently</u> to improve your health? Check all that apply.

☐ Gluten-free diet	☐ Yoga	☐ Work Habits	☐ Chiropractic
☐ Herbs	☐ Massage	☐ Relationships	☐ Acupuncture
☐ Fasting	☐ Sleep/rest	☐ Therapy	☐ Other

What are your spiritual beliefs or religious practices? _____

Please circle all that apply:

Increased secretions in mouth/nose/eyes	Decreased secretions in mouth/nose/eyes	Dry skin
Swelling in hands and feet	Dry mouth and skin	Tremors
Cold hands and feet	Inability to concentrate	Inability to control blood pressure
Muscle cramps at night	Muscle cramps during exercise	Inability to conceive
Menstrual cramps	Muscle weakness	Inability to induce labor
Bleeding gums	Easily startled	Spontaneous abortion
Does not tolerate exercise	Loss of energy and fatigue	

Are you pregnant or nursing? ☐ Yes ☐ No Are you Pre ____ or Post_____ Menopausal

On a scale of 1-10, how would you rate your willingness to be coached and make changes to your current lifestyle to address you health challenges? **1 = low, 10 = extremely high _____**

Who may we thank for referring you to B Renewed Wellness Center? _____

By signing below, I understand that consultations with Dr. Bonnie Schnautz, ND and staff of B Renewed Wellness Center are not intended to diagnose treat, or cure. This consultation is for educational purposes only and not a substitution for medical care.

Client Signature:_____Date: _____