Well-being Form

Name:		Email:	
D.O.B:		Address:	
Contact Number:		Referred By:	

SECTION ONE:
*Please answer the questions honestly and to the best of your ability. At times we may not see our situation or symptoms accurately, here it is advised to ask someone close to you to give you their observation.

1.Describe the issue(s) that you are seeking guidance for. If possible please mention when the issue first occurred in your conscious memory (max 3 issues):

2.Past medical history. List and describe any: injuries, traumas, accidents, surgeries etc, please mention dates of occurrence:

3.List any clinical or natural medications/supplements/vitamans you are currently taking:

4.List any medications you have taken in the past 10 years:

5.List any medications you were given during childhood (include any vaccinations that were administered):

6.Please mention any other health care practitioners you have consulted in the past year:

7.List any medical test you have had during the past year:

8. Write down 3 goals you have for you physical health:

*Please mark the circle that best represents the frequency at which you experience the below issues.

1.Rarely 2.Occasionally 3.Often 4.Always

DIGESTION:					
1 2 3 4	Loose stool	1 2 3 4	Gas and belching	1 2 3 4	Blood in stool
1 2 3 4	Bloating	1 2 3 4	Reflux	1 2 3 4	Inflammation
1 2 3 4	Cramps	1 2 3 4	Gastro	1 2 3 4	Candida
1 2 3 4	Tired after eating	1 2 3 4	Full after eating	1 2 3 4	Constipation
1 2 3 4	Poor digestion	1 2 3 4	Gall stones	1 2 3 4	Heartburn
1 2 3 4	Parasites	1 2 3 4	Excessive appetite	1 2 3 4	Poor appetite
1 2 3 4	Irritable bowels	1 2 3 4	Light colored stool	1 2 3 4	Dark colored stool

RESPIRATORY:					
1 2 3 4	Wet cough	1 2 3 4	Dry cough	1 2 3 4	Chest tightness
1 2 3 4	Wheezing	1 2 3 4	Shortness of breath	1 2 3 4	Congestion
1 2 3 4	Nasal problems	1 2 3 4	Poor sense of smell	1 2 3 4	Sinisitus
1 2 3 4	Allergies	1 2 3 4	Hay fever	1 2 3 4	Asthma
1 2 3 4	Bronchitis	1 2 3 4	Bird flu	1 2 3 4	Nasal problems
1 2 3 4	Congestion	1 2 3 4	Catches colds easily	1 2 3 4	Pneumonia
1 2 3 4	Emphysema	1 2 3 4	Pleurisy	1 2 3 4	Smoking

CARDIOVASCULAR:					
1 2 3 4	Hypertension	1 2 3 4	Restlessness	1 2 3 4	Heart disease
1 2 3 4	Hypotension	1 2 3 4	Heart palpitations	1 2 3 4	Phlebitis
1 2 3 4	Chest pain	1 2 3 4	Slow heart rate	1 2 3 4	Fast heart rate
1 2 3 4	Poor circulation	1 2 3 4	Dizziness	1 2 3 4	Poor blood clotting
1 2 3 4	Easily bruised	1 2 3 4	Blood clots	1 2 3 4	Stroke
1 2 3 4	Edema	1 2 3 4	Sweaty hands/feet	1 2 3 4	Cold hands/feet
1 2 3 4	Anemia				

URINARY:					
1 2 3 4	Painful urination	1 2 3 4	Ear aches	1 2 3 4	Lower back pain
1 2 3 4	Incontinence	1 2 3 4	Hearing impairment	1 2 3 4	Knee problems
1 2 3 4	Difficult urination	1 2 3 4	Kidney Stones	1 2 3 4	Ringing ears
1 2 3 4	Kidney infection	1 2 3 4	Gas and belching	1 2 3 4	Blood in stool

OTHER:			
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

Comments:

SECTION TWO

1. Describe your personality:

2. List 3 goals you would like to achieve in regards to your mind:

3. List 3 goals you would like to achieve in your career:

4. List 3 goals you would like to achieve in your personal/romantic life:

5. List 3 goals you would like to achieve in your spiritual/religious life:

6. Describe 3 emotions you love to feel and experience:

7. Describe 3 emotions you want to rid from your life that bring about negativity:

Signature: