the wellness centre of Baton Rouge

Where the only side effect is wellness

CLIENT INFORMATION AND HEALTH HISTORY FORM

General Information:

Name: _____ Date: _____

Date of Birth: _____ Sex: F □ M ■ Height: _____ Weight: _____

Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship Status: Single: □ Married: □ Divorced: □ Widowed: □

Occupation: _____

Emergency Contact Information:

Name: _____ Phone: _____

Relationship: _____

Practitioner Notes:

Please List 5 Main Health Concerns You Have in Order of Importance

(1 Being Most Important; 5 Being Least Important)

1._____

2._____

3._____

4._____

5._____

On a scale of 1 - 10 (10 being highest), how willing are you to change your current habits?

1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do You Feel Stressed?: Yes ☐ No ☐ Sometimes ☐

What Causes Most Of Your Stress?

_____

_____

Are you currently seeing a medical doctor for any reason?: Yes ☐ No ☐

If Yes, Please Explain:

_____

_____

_____

_____

_____

Please list any prescription medication you are currently taking:

Medication	*Date Prescribed*	*Purpose*

Please list any supplements you are currently taking:

Supplement	*Date*	*Purpose*

Please list any surgeries you have had:

Surgery	*Month/Year*	*Purpose*

		How Many? / Date(s) of Procedure(s)
Yes ■ No ■	Root Canals	
Yes □ No □	Crowns	
Yes □ No □	Implants	
Yes □ No □	Dentures	
Yes □ No □	Braces	
Yes □ No □	Mercury (Amalgam) Fillings	

Do You Have A Regular Bowel Movement Before Noon Each Day? Yes: ■ No: □

Two Or More Bowel Movements Per Day?: Yes: □ No: □

Constipated?: Yes □ No □ Diarrhea?: Yes □ No □

Do You Feel Rested?: Yes □ No □

How Much Sleep Do You Get Per Night? _____(hrs)

What Time Do You Normally Go To Bed? _____

Do You Wake Up in The Night?: Yes □ No □ Sometimes □

What Time(s) or How Many Times? _____

Do You Wake Up To Go To The Bathroom?: Yes □ No □ Sometimes □

Describe Your Energy Level:

_____

_____

_____

_____ Do You Exercise?: Yes □ No □

How often and what form of exercise?

_____

_____

Blood Type: _____ Have You Been Vaccinated? Yes □ No □

Which vaccines have you had in the last year and date?

Flu _____ Shingles _____ Gardisil _____ Pneumonia _____

Covid _____ □ Pfizer □ AstraZeneca ■ Moderna □ Johnson & Johnson)

Are You Pregnant? Yes □ No □ Due Date: _____

Number of Children and Their Ages: _____

List Your Childhood Traumas:

_____

_____

Your Adult Traumas:

_____

_____

Do You Smoke: Yes☐ No☐ Times Per Day/Week: _____

Approximately How Many Ounces Water Do You Drink A Day?: _____

Distilled:☐ Reverse Osmosis:☐ Spring:☐ City Tap:☐ Well:☐

How many of these beverages do you consume per day?

Coffee: □ _____ Sweet Tea: □ _____ Green Tea: □ _____

Energy Drinks: □_____ Black Tea: □ _____ Bottled Juice: □_____

Soda: □ _____ Herbal Tea: □ _____

*List The Three **Worst** Foods You Eat During The Average Week:*

1._____ 2._____

3._____

TOXIC BURDEN

Please check off the symptoms you are regularly experiencing under each category and any details.

	BACTERIA	LIST CONCERNS
	Yellow/green discharge	
	Fever gets worse with time	
	Symptoms persist longer than 10-14 days	
	Focal area of illness(sinuses,lungs,throat)	
	VIRUSES	**LIST CONCERNS**
	Clear discharge	
	Low-grade fevers/chills	
	History of chronic viral infection(EBV,HPV,etc)	
	Body-wide aches/fatigue	
	MOLD/FUNGUS	**LIST CONCERNS**
	Frequent antibiotic usage	
	Fungal rashes/eczema/psoriasis/yeast infect	
	White, coated tongue	
	Strong cravings for sugars and starches	
	LYME	**LIST CONCERNS**
	History of tick bite	
	Neurological symptoms/confusion/heavy feeling	
	Diagnosis of Lyme, MS.Lupus,Autism	
	Excruciating joint pain, non-related arthritis	
	HEAVY METALS	**LIST CONCERNS**
	Currently have silver fillings/had removed	
	Exposure of vaccines	
	Memory Difficulties	
	Tremors/Alzheimer’s/Parkinson’s	

	CHEMICALS	LIST CONCERNS
	Chemical exposure home/work (salon, plant	
	Use commercial cleaning products(Lysol,etc)	
	Use commercial personal products(Dove,etc)	
	Currently smoke or exposed to smoke	
	PESTICIDES	**LIST CONCERNS**
	Eat non-organic produce/animal products	
	Use fertilizer/Round Up on yard	
	Drink/bathe in unfiltered tap water	
	Pesticide exposure from work	
	PARASITES	**LIST CONCERNS**
	History of digestive upset	
	Bloating/gas	
	Itching skin, especially at night	
	Irritable bowel/Crohn's/Celiac	

DIGESTION

You are not what you eat...you are what you DIGEST! Please check all that apply currently.

- ☐ Acid reflux/heartburn
- ☐ Belching after fatty meals
- ☐ Bloating after eating carbs/sugar
- ☐ Constipation or bowel movt less than 1x day
- ☐ General indigestion after eating
- ☐ I am 25+ years old, I want to optimize my digestion
- ☐ Mild sensitivity to gluten and/or dairy
- ☐ Stools float or light in color
- ☐ Took antibiotics without probiotics
- ☐ Ulcer or pain after eating

GENERAL SYMPTOMS

Check all that apply.

- ☐ Headaches
- ☐ Weakness
- ☐ Losing weight, underweight
- ☐ Insomnia, wake up at night
- ☐ Very sensitive to cold
- ☐ Post Traumatic Stress
- ☐ Tired, yet can't relax
- ☐ Bad breath
- ☐ Night sweats/Hot Flashes
- ☐ Weakness due to low blood sugar
- ☐ Fainting spells, dizziness
- ☐ Heart Palpitations
- ☐ Dry eyes, sore throat
- ☐ Brain fog, concentration lack
- ☐ Anxious, fearful, worried
- ☐ Poor Stamina
- ☐ Flushed face
- ☐ Excessive thirst
- ☐ Very sensitive to heat
- ☐ Nausea

WOMEN ONLY

Do you get a monthly period? Yes ■ No □

Have you had a hysterectomy? Yes ■ No □ Full / Partial

If menopausal, list all symptoms:

_____

_____

_____

MEN ONLY

Have you had a drop in muscular strength, drive or libido? Yes ■ No □

Do you have difficulty urinating or have an enlarged prostate? Yes □ No □