The Wellness Centre
of Baton Rouge

CLIENT INFORMATION AND HEALTH HISTORY FORM

General Information:

Name: _____ Date: _____

Contact Phone: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: F ☐ M ☐ Height: _____ Weight: _____

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?

_____

_____

What do you do when you are stressed?

_____

_____

Do you feel you have an outlet or a way to relieve stress, and what is it?

_____

_____

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

If Yes, Please Explain:

_____

_____

_____

_____

_____

Please list any Medication you are currently taking:

Medication	*Date Prescribed*	*Purpose*

Please list any Supplements you are currently taking:

Supplement	*Date*	*Purpose*

Dental History:

Do You Have Any of The Following?

		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	

Please List any Surgeries you Have Had:

Surgery	*Month/Year*	*Purpose*

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)

Right or Left-Handed? R ☐ L ☐ | Are You Pregnant? Yes ☐ No ☐ | Due Date: _____

Number of Children and Their Ages: _____

Have you had any abortions: Yes ☐ No ☐ | How many? : _____

Have you had any miscarriages: Yes ☐ No ☐ | How many? : _____

Have you had any of your children die? : Yes ☐ No ☐

Were Your Children Born By Vaginal Delivery Or C Section? : _____

Were There Any Medications Administered During Labor? : Yes ☐ No ☐

If Yes, Please List Which Ones: _____

Did You Nurse, Or Are You Currently Nursing? : Yes ☐ No ☐

Birth History:

Were you born at home, in a hospital, or birthing center?_____

Were you born by vaginal delivery or c-section? _____

Did your mom have an epidural during your labor? Yes ☐ No ☐ Unsure ☐

Was there any pain medication administered during labor? Yes ☐ No ☐ Unsure ☐

Was the medication pitocin used to induce labor? Yes ☐ No ☐ Unsure ☐

Were you adopted, raised by your biological parents, or other?_____

If other please explain:

_____

_____

_____

Were you nursed or bottle fed? _____

Which state and country did you grow up in?_____

Health History:

Health of Mom:

_____

_____

_____

Health of Dad:

_____

_____

_____

How many siblings do you have? _____ What Number Are You In Birth Order? _____

List Childhood Traumas:

_____

_____

_____

_____

Adult Traumas:

_____

_____

_____

_____

Food and Beverage Consumption

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

1. _____

2. _____

3. _____

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

1. _____

2. _____

3. _____

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

Approximately How Much 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: ☐ _____

Do You Use A Juicer? Yes ☐ No ☐

If Yes: Vita Mix Or Extractor? _____ How many times per week? _____

How many alcoholic beverages do you consume per week? _____

What type of alcohol do you consume (beer, wine, etc.)? _____

How many times do you eat out per week? _____

How many times do you eat fish per week? _____

How many times do you eat raw nuts or seeds per week? _____

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 1xday
- ☐ General indigestion after eating
- ☐ Hard, small, very loose or stringy stools
- ☐ I am 25+ years old, 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
- ☐ Other: _____

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
- ☐ Very tired in morning, hard to get up
- ☐ 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
- ☐ Water retention, swelling

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

Do you have a drop in muscular strength, drive or libido? Yes ☐ No ☐

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