Experience the Perks of Wellness

Today's Date _____

GENERAL INFORMATION:

Full Name _____ Age ____ DOB _____

Height _____ Weight _____

Contact Numbers:

Home _____

Work _____

Cell _____

Email Address _____

How do you prefer to be contacted? Call Text Email

Occupation _____

Home Address _____

City _____ State _____ Zip _____

Marital Status: S M D W Name of Spouse/Partner _____

Names and Ages of Children

_____

Parent's Name (if you are under 18 years of age)

_____

Emergency Contact _____

Phone Number (____) _____

Who may we thank for referring you to Perks of Wellness?

_____

REASONS FOR SEEKING CARE

What concerns do you feel Perks of Wellness can address for you?

_____

_____

_____

Is the above concern affecting any of the activities below? (Please circle)

Work:	Y	N	Recreation/play:	Y	N	Sleep:	Y	N
Social Life:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise:	Y	N	Eating:	Y	N	Other:		

At Perks of Wellness we focus on your body's ability to be healthy and well. The idea is that you should be able to do what you want to do, when you want to do it. Our first goal is to address why you came to the office. Next is to explore ways to improve your health and wellness. Your health and wellness is the balance between physical, chemical and emotional stresses. These stresses accumulate and can result in a loss of health potential. Usually the effects are gradual, and are not addressed until they become serious. Understanding the physical, chemical and emotional stresses you have accumulated allows us to better assess the challenges to your full health potential.

HISTORY OF PHYSICAL STRESS (birth to present)

Most traumas occur in the early years (between birth and the early twenty's). We are looking for patterns in your life. Do you attract "accidents?"

Have you had any accidents related to the following? (Circle all that apply & give dates)

Auto Motorcycle Bicycle Sports Other

If yes, please explain (use the back of this page if necessary):

_____

_____

_____

Have you broken any bones or sprained any part of your body? Y N
If yes, please explain:

_____

_____

Have you ever had a surgery or have been hospitalized? Y N

_____

_____

Do you participate in sports as an adult? Y N
Do you sit at a computer for long periods? Y N

On a scale of 1 – 10 describe your stress level
(1 = none, 10 = extreme) Work Stress _____ Personal Stress _____

HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken orally, or placed on the skin that is toxic to the body. The following will give us insight into any exposures you may have had.

Have you been vaccinated? Y N

Do you currently or have ever taken? (Circle those that apply)

Prescription drugs Over the counter drugs Recreational drugs

List the drugs you are now taking & for what condition:

_____ _____

_____ _____

_____ _____

List any supplements you take daily & why:

_____ _____

_____ _____

_____ _____

Have you been exposed to or currently exposed to? (Circle those that apply)

Chemicals	Fumes	Dust
Smoke	Air pollution	Water Pollution

Do you consume: Alcohol Coffee/caffeine Tobacco

How much water do you drink in a day? _____

HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the emotional stress in our lives from the physical response that often occurs. Please indicate if you have ever experienced any of the emotional stresses below: (Please circle those that apply)

Childhood trauma	Y N	Loss of loved one	Y N	Illness	Y N
Relationships	Y N	Family	Y N	Work/ School	Y N
Divorce/separation	Y N	Financial	Y N	Abuse	Y N
Lifestyle change	Y N	Parental divorce	Y N	Other	Y N

QUALITY OF LIFE (Please circle those that apply)

How do you grade your physical health?	Good	Fair	Poor
How do you grade your emotional/mental health?	Good	Fair	Poor
How do you rate your overall "quality of life"?	Good	Fair	Poor
Do you like the experiences you are attracting?	Yes	No	
Would you like to attract different experiences?	Yes	No	
Are you willing to make changes to your lifestyle?	Yes	No	

On a scale of 1 to 10, with 1 being not satisfied and 10 being extremely satisfied; Please rate the following four areas:

SUCCESS	1	2	3	4	5	6	7	8	9	10
HEALTH	1	2	3	4	5	6	7	8	9	10
RELATIONSHIPS	1	2	3	4	5	6	7	8	9	10
PERSONAL GROWTH	1	2	3	4	5	6	7	8	9	10

Would you like to explore these four categories in more depth? Y N

Using poor – good – excellent

Diet: _____ Sleep: _____

Exercise: _____ General Health: _____

Which areas of health would you like to know more about?

Eating	Rest	Breathing
Drinking	Exercise	Thinking
	All of the Above	

Would you be willing to investigate any subconscious interference that may be getting in your way? Yes / No
(You would not have to reveal any personal information)

We are not only concerned with your health and wellness, but that of your family and friends. Are there any health concerns you have about your….?

Children _____

Spouse/ Partner _____

Parents _____

Siblings _____

Other _____

_____ _____

Signature Date

_____ _____

Signature of Parent (for minor) Date