ENERGY WELLNESS CENTER OF ORLANDO

Client Information

Name _____ **Age** _____
Address _____
Telephone (best) _____ **Email** _____

Reason for visit (prioritized):

1._____
2._____
3._____

Nutritional data:
How many ounces of water/day? _____What kind? _____
What other beverages and how much? _____
Do you use artificial sweeteners?_____ If so, which ones? _____
How often and in what? _____
Do you eat breakfast? _____ If so, what? _____

How many servings per week? (example: raw apple = 1 fresh fruit; salad = 1 raw vegetables)
Fresh fruit _____ Raw vegetables _____ Fermented foods _____
Fast foods _____ Meat _____ Eggs _____ Dairy _____
What do you crave? _____
What foods do you dislike the most? _____
Why? _____
_____

Timing:
What is the first thing you do when you get up in the morning? _____
_____
What time do you eat your first meal? _____ Last meal? _____
Which meal is your largest of the day? _____
Describe a typical "largest meal". _____
_____

Movement:
Do you exercise/move/participate in fun sweaty activity? If so, what and how often?
_____
_____
Do you look forward to it? _____
How do you feel when you are finished? _____

Sleep:
What time do you go to bed? _____ How long do you sleep? _____
Do you wake often? _____
If so, why and at what time(s)? _____
Do you feel rested when you wake up for the day? _____
Do you have pain when you first get up? _____ If so, where?_____
_____
Does it go away upon moving? _____

Eliminations:
Do you have daily bowel eliminations? _____ If yes, how many per day?_____
If no, please describe your elimination pattern._____
_____

Females:
Are you post-menopausal? _____ If yes, at what age did you enter menopause? _____
What were the characteristics of your menopausal experience? _____
_____
Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? _____
Are you now, or in the near future, planning to become pregnant? _____
Is your menstrual cycle regular? _____ Longer than 28 days? _____ Shorter? _____
Is your flow longer or shorter than 5 days? _____
Do you have cramps or clotting? _____ Would you describe the color of your menses as more red, more purple, or more brown? _____
Do you experience PMS, cyclical headaches, or cravings? _____

Supplements/medications:
Do you take any supplements? _____ If so, what, how often and why? _____
_____
_____
Do you take any OTC medications routinely (such as Aleve or Aspirin)? If so, what and how often? _____
Do you take prescription medications (prescribed by a licensed medical professional?) If so, what and how often? _____

Medical history:
Have you had any surgeries? If so, what and when? _____
_____
Have you received any diagnoses (including allergies) from a licensed medical professional? If so, what and when? _____
_____

I understand that I am here to learn about lifestyle and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on holistic wellness matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature _____Date _____