

Wellness 1st Integrative Medical Center, LLC

Initial Consultation/ Wellness Evaluation (Please Be Honest & Fill Out Completely)

Name: _____ Age: _____ Date: _____

Main Complaints/ Unwanted Health Problems:

- 1) _____ 2) _____
3) _____ 4) _____

How long have you been suffering with this/these problem/s?: _____

Any other complaints/ issues: _____

Would you like improvement with any of the following?:

- Digestion: Reflux, Gas, Constipation, Diarrhea Sense of Well Being
 Sleep: Falling asleep or staying asleep Energy Mental Clarity, Memory

What have you tried doing to resolve this problem that Did Not work?

Have you become discouraged or stressed about handling this problem?

When your problem is at its worst, how does it make you feel?

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this/these problem/s may have started?

What effect does this have on your body functions? _____

Are you here visiting us to:

- a) Resolve my immediate problem b) Lifestyle program for optimized living c) Both
d) Other: _____

How have you taken care of your health in the past?

- | | |
|--------------------|--------------|
| Medications | Holistic |
| Routine medical | Vitamins |
| Exercise | Chiropractic |
| Diet and Nutrition | Other: _____ |

How did the previous methods work for you? _____

What are you afraid this might affect if no change is made? Please Circle

Job Marriage Freedom Future Abilities Kids Sleep
Finances Time Relationships Life

What health conditions you are afraid this might turn into? Please Circle

Arthritis Cancer Depression Diabetes Diminished Future Abilities
Heart disease Surgery Stress Weight gain Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is NOT taken care of? Please be specific

What would be different or better without this problem? Please Circle:

Confidence Family Diminished stress Healthy Self esteem Sleep
Outlook Work More Energy

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

Are there potential barriers that would prevent these goals from happening?

How can we eliminate or prevent these potential barriers?

Tell me your strengths that will enable you to accomplish your goals?

How long have you been thinking about getting rid of your health condition/s? ___ days ___ months ___ years

On a scale of 1-10:

- _____ How important is it for you to resolve your health concerns?
- _____ Do you feel that you are coachable and would enjoy a mentor in helping you?
- _____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?
- _____ Are you ready to get started today?

Do you believe your health condition/s: Check One

- _____ Have been going on for too long & may require a lot/ some work?
- _____ Have been going on for a short time & may require a little work?
- _____ Have just come about and may require minor work?
- _____ I'm happy with my health condition and it doesn't need any work?

Thank You & God Bless!