ON THE MARK HEALTH AND WELLNESS

PROFILE

The following information is the basis for the relationship you are creating with your health counselor. Please complete this form as frankly as possible, know all information will be kept in the strictest of confidence. We look forward to guiding you on a successful journey to optimal health.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Blood Type _____

Occupation _____ Hours of work per week: _____

Marital Status _____ Do you have children? _____ Ages: _____

CURRENT HEALTH

What is the primary concern that prompted your visit?

_____

_____

Please list your secondary concerns?

_____

_____

Do you ever feel tired or weak? ☐ Yes ☐ No If so, please detail when this happens: _____

_____

Please list all supplements and/or traditional medication you are currently using:

_____

_____

_____

Please define the relationship and provide contact information for any holistic and/or traditional healthcare providers you are currently working with:

_____

_____

Please indicate if you have any of the following:

☐ Acne ☐ Ankle Swelling ☐ Backache ☐ Balance Issues ☐ Blood in Urine
☐ Burning During Urination ☐ Constipation ☐ Depression ☐ Diarrhea ☐ Dizziness
☐ Difficulty Holding Urine ☐ Dry Skin ☐ Dry Heels ☐ Fainting ☐ Headaches
☐ Joint Swelling or Stiffness ☐ Kidney Stones ☐ Leg Cramps ☐ Neck Pain or Stiffness
☐ Numbness ☐ Rashes ☐ Tingling in Extremities

Name: _____ Date: _____

MEDICAL HISTORY

Please detail any injuries, hospitalizations or serious health conditions:

_____

_____

DENTAL HISTORY

Please detail any general dental work you have had: _____

_____

Have you had your wisdom teeth removed? ☐ Yes ☐ No Were they impacted? ☐ Yes ☐ No

Do you bleach your teeth? ☐ Yes ☐ No How often? _____

MENTAL HEALTH

Do you have recurrent periods of depression? ☐ Yes ☐ No

Does anything specific bring on your depression? _____

_____

Do you experience notable anxiety? ☐ Yes ☐ No If so, when? _____

_____

Do you have issues with focus and concentration? ☐ Yes ☐ No o

WOMEN'S HEALTH

Are your periods regular? ☐ Yes ☐ No How many days is your flow? _____ Frequency: _____

Are your periods painful or symptomatic? ☐ Yes ☐ No How so? _____

Are you currently on birth control? ☐ Yes ☐ No What kind? _____

FAMILIAL HEALTH

Please detail the health issues of any immediate family member.

_____

_____

WEIGHT

Current: _____ Six Months Ago _____ One Year Ago _____

What is your goal weight? _____ When were you last your goal weight? _____

What is your motivation to change your weight? _____

Are you willing to modify your lifestyle to achieve your goal? ☐ Yes ☐ No

If so, what lifestyle changes do you think you need to make? _____

_____

_____

SLEEP

How many hours a night do you typically sleep? Weekdays: _____ Weekends: _____

Do you wake throughout the night? ☐ Yes ☐ No If so, how many times? _____

How long have you been waking throughout the night? _____

Do you have difficulty: falling asleep? ☐ Yes ☐ No waking up? ☐ Yes ☐ No

Name: _____ Date: _____

EXERCISE

Do you currently exercise? ☐ Yes ☐ No If so, please note your activities below:

Description of Activities	Frequency

Would you consider using a personal trainer? ☐ Yes ☐ No

HABITUATION

Do you currently smoke? ☐ Yes ☐ No If so, how much? _____ How often? _____

Do you drink alcohol? ☐ Yes ☐ No How much & often do you drink each of the following:

Wine: _____ Beer: _____ Liquor: _____

Do you drink coffee/soda? ☐ Yes ☐ No How much coffee? _____ How much soda? _____

Have you ever used narcotics, stimulants or depressants on a regular basis? ☐ Yes ☐ No

How long ago did you discontinue use? _____ If not, how often do you currently use? _____

EATING HABITS

What do you typically eat?

Breakfast	Lunch	Dinner	Snacks	Liquids

Have your eating habits changed in the past year? ☐ Yes ☐ No

What did you typically eat a year ago?

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you have food cravings? ☐ Yes ☐ No If so, what do you crave? _____

What foods disagree with you? _____

How frequently do you eat? _____

What percentage of your food is home cooked? _____ Who cooks in your home? _____

Where is the rest of your food from? _____

ADDITIONAL INFORMATION

ON THE MARK HEALTH AND WELLNESS

HEALTH & WELLNESS AUTHORIZATION & ACKNOWLEDGEMENT

1. SERVICES: My health care provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription of legend drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept.

2. NO GUARANTEE: I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. Prorated fees for unused, prepaid services, however, will be refunded if I wish to cancel. No refunds will be available for any products purchased.

3. RISKS: I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any legend drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients.

4. PREGNANCY: I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

5. ALTERNATIVES: I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

6. QUESTIONS AND ANSWERS: I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature _____ Date _____

Name (printed)_____