The True Wellness Center

A European BioRegulatory Approach to Health

True Wellness Client Information

Name _____ Today's Date _____

What name do you prefer to be called? _____

Date of Birth _____ / _____ / _____ Sex: M ___F ___

Address _____

City _____ State _____ Zip _____

Email: _____

Home Phone _____ Cell _____

Occupation _____ How Long? _____

Marital Status (Circle One) Single Married Separated Divorced Widowed

Spouse's Name _____

Please explain the reason for your visit today: _____

_____

_____

Circle all the different types of practitioners you have been to in the past:

Nutritionist Homeopath Naturopath Chiropractor Acupuncturist

SUBSTANCE SURVEY

Please list any medications, vitamins, supplements, herbs or other homeopathic medicines you are currently taking or have taken in the last year. (Use other side if necessary).

Product / Medication	Amount Taken	How Long Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

921-B North Bethlehem Pike, Suite 2
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www.TheTrueWellnessCenter.com

ALLERGIES TO MEDICATIONS: _____

MEDICAL HISTORY:

_____

_____

_____

_____

SURGERY HISTORY:

_____

_____

SOCIAL HISTORY: Check the following that apply to you and indicate amount used, etc.

Drugs ____ _____
Smoke ____ _____
Drink ____ _____
Tattoos ____ _____

Diet:

Check the following items which apply to you and indicate the amount used (i.e. 3 times a day, daily, weekly, monthly):

Coffee	_____	Antacids	_____	Alcohol	_____
Tea	_____	Soft Drinks	_____	Laxatives	_____
Candy	_____	Cigarettes	_____	Other Tobacco Products	_____
Ice Cream	_____	Recreational Drugs	_____		

How many desserts do you have a week? _____

FOOD AND HABITS SURVEY

Eat Cow Dairy Y N How often? _____
Eat Fast Food Y N How often? _____ Eat Pork Y N How often? _____
Eat Shell Fish Y N How often? _____ Eat White Flour Y N How often? _____
Eat White Sugar Y N How often? _____
My Daily Diet typically consists of:
Vegetables % of diet _____ Rice, Breads, Cereals % of diet _____
Lean Meats (poultry, fish) % of diet _____ Meat (beef, pork, game) % of diet _____
Fruits % of diet _____ Nuts, Beans, Seeds % of diet _____

Daily water intake: How many glasses per day? _____
Exercise? Y N How Often? _____
Eat organically? Y N How Often? _____
Do you eat after 7:30 PM? Y N How many times per week? _____
Do you eat 3 meals per day? Y N If not 3, how many? _____

PERSONAL HISTORY SURVEY

Do you suffer from any of the following? Please summarize how many times a day and when.

HEAD

Headaches Y N Migraines Y N Frequency? _____
Pressure Y N Dizziness Y N Fainting Y N
Summarize: _____

MIND

Poor memory Y N Poor Concentration Y N
Confusion Y N Poor Coordination Y N
Summarize: _____

EARS

Itchy Ears Y N Ear Aches Y N
Summarize: _____

EYES

Blurred Vision Y N Watery, Itchy Eyes Y N
Swollen Eyelids Y N Dark Circles Y N
Are these symptoms seasonal or constant?_____
Summarize: _____

NOSE

Stuffy Nose Y N Sinus Problems Y N
Excessive mucous Y N Sneezing Attacks Y N
Are these symptoms seasonal or constant?_____
Summarize: _____

MOUTH

Do you currently have or have you ever had amalgam (silver) fillings? Y N
If you had amalgams removed, when did this take place and who was the dentist:
_____
Do you currently have or have you ever had root canals? Y N
Did you have braces? Y N
Summarize: _____

LUNGS

Shortness of breath Y N Need to Clear Throat Y N
Asthma Y N Chronic Cough Y N
Difficulty Breathing Y N
Are these symptoms seasonal or constant? _____
Summarize: _____

DIGESTIVE

Nausea Y N Constipation Y N Loose stools Y N
Bloating/Gas Y N Indigestion Y N Heartburn Y N
Poor appetite Y N
Summarize: _____

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SKIN

Acne	Y	N	Eczema	Y	N	Cirrhosis	Y	N
Excessive Sweating	Y	N	Hives, dry skin	Y	N	Cold sores	Y	N
Dermatitis	Y	N	Other Rashes	Y	N			

Summarize: _____

JOINT / MUSCLES

Joint Pain	Y	N	Feeling Weak	Y	N	Numbness	Y	N
Joint swelling	Y	N	Stiffness	Y	N			

Summarize: _____

WEIGHT

Current Weight _____ Weight at 18yo _____

Emotional Eating	Y	N	Craving certain foods	Y	N	Excessive Weight	Y	N
Compulsive Eating	Y	N	Water Retention	Y	N	Underweight	Y	N

Summarize: _____

EMOTIONS

Mood Swings	Y	N	Anxiety, fear, nervous	Y	N			
Anger, irritability	Y	N	Depression	Y	N	Apathy / lethargy	Y	N

Summarize: _____

ENERGY / ACTIVITY

Fatigue	Y	N	Insomnia	Y	N
Hyperactivity	Y	N	Restlessness	Y	N

Summarize: _____

WOMEN ONLY

P.M.S.	Y	N	Hot Flashes	Y	N

Birth Control Pill Currently taking _____ Have ever taken _____ When_____ How long ____

Summarize: _____

OTHER

Allergies	Y	N	Other sensitivities	Y	N
Body Pain	Y	N	Sexual dysfunction	Y	N
Night sweats	Y	N	Frequent Illness	Y	N
Leaky bladder	Y	N	Genital Itch	Y	N
Frequent or urgent urination	Y	N	Hemorrhoids	Y	N

Summarize: _____

Have you been in fresh water? Y N If yes, where? _____

Where were you born? _____

What are your family's medical history/problems? _____

_____

_____

_____

_____

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CONSTITUTIONAL ANAYLSIS

Reported Stress Level (out of 10) ____ Reported Anxiety Level (out of 10) ____
Is this normal for you?___

How do you feel stress in our body physically? ↑Muscular Tension ↑Headaches ↑Grind Teeth
Digestive Disturbances _____ ↑Compulsive Movements (i.e. nail biting)

Do you frequently feel? ↑Fearful ↑Timid/Shy ↑Irritable ↑Sad ↑Impulsive
↑Easily Excitable ↑Angry ↑Obsessive/Worried
↑Absent Minded/Dull/Confused ↑Weepy ↑Critical ↑Withdrawn

How does your mood change when your symptoms flare up? _____
_____

Any sensation in your body of ↑Heaviness ↑Dullness ↑Heat ↑Cold ↑Numbness ↑Bloating
Where do you feel this sensation? _____

Women (only) – do you experience any of the following with your periods: ↑
Excessive bleeding/Clots ↑Irregular cycles ↑Absent Menstruation Fainting
↑Cycles longer than 4-5 days ↑Excessive Pain ↑Severe Mood Swings ↑Nausea/Vomiting
↑Low Back Pain or Hip areas ↑Other _____

How long has this been the case? _____

List your Top 3 Symptoms/Complaints, in order of importance to you:

1. _____ Since: ___ /___ /___ # of Years: _____
2. _____ Since: ___ /___ /___ # of Years: _____
3. _____ Since: ___ /___ /___ # of Years: _____

What do you believe caused this condition?
_____
_____
_____

What in your life brings you JOY? _____
_____
_____

Are you currently under the care of a physician? _____

For what purpose? _____
_____
_____

Diagnosis given by doctor _____

Doctor's Name: _____ Phone Number: _____

What is your blood type? _____

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What else do you want us to know :

_____
_____
_____
_____
_____
_____

Referred by / How did you hear of us? _____

Client Signature: _____ **Date:** _____

True Wellness: _____ **Date:** _____