NATURE'S WISDOM WELLNESS ASSOC.

54 HIGH STREET
WESTERLY, RI 02891

CLIENT ASSESSMENT FORM
HEALTH PROFILE

NAME _____AGE_____DOB_____

ADDRESS_____City_____State_____

Zip_____PHONE_____

EMERGENCY CONTACT_____PHONE_____

REFERRED BY? _____

EMAIL ADDRESS_____

DO YOU HAVE AN IMPLANTED PACEMAKER OR DEFIBRILLATOR? ARE YOU PREGNANT? IF YES INFORM DR STANTON BEFORE VISIT. YOU WILL NOT BE ABLE TO HAVE ONDAMED THERAPY OR ASYRA

._____

ALLERGIES? _____

CURRENT SYMPTOMS/HEALTH COMPLAINTS OR CONCERNS

_____

_____

_____

DURATION OF ABOVE_____

HAVE YOU BEEN TREATED FOR THE ABOVE? IF YES PLEASE DESCRIBE

_____

_____

_____

ARE YOU PRESENTLY TAKING ANY PRESCRIPTION MEDICATIONS? PLEASE LIST

_____

_____

ARE YOU PRESENTLY TAKING ANY HERBS, VITAMINS, OR SUPPLEMENTS?
_____

_____

PAST MEDICAL HISTORY
PLEASE LIST ANY DIAGNOSES, CONDITIONS, ETC.

_____

_____

_____

PLEASE LIST ANY SURGERY

_____

_____

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT?_____

DO OR DID YOU SMOKE?_____ HOW MUCH? _____FOR HOW LONG?_____

DO YOU DRINK ALCOHOL?_____ HOW MUCH?_____HOW OFTEN?_____

DO YOU? HAVE YOU USED ILLEGAL DRUGS?
(CONFIDENTIAL)_____

DO YOU DYE/BLEACH YOUR HAIR? _____HOW OFTEN? _____

HOW MUCH WATER DO YOU DRINK PER DAY? # OF GLASSES_____

HOW MANY FRUITS PER DAY?_____

HOWMANY SERVINGS OF VEGETABLES PER DAY? cooked_____Raw_____

DO YOU EXERCISE?
HOW OFTEN ?_____FOR HOW LONG?_____TYPE_____

HOW DO YOU SLEEP?_____
HOW MANY HOURS PER NIGHT DO YOU SLEEP? _____
DO YOU WAKE UP AT NIGHT? _____CAN YOU FALL BACK ASLEEP?_____
_____

DO YOU FEEL RESTED WHEN YOU WAKE UP?_____

HAVE YOU BEEN THROUGH ANY SERIOUS TRAUMA? WHEN? THIS CAN BE ANYTHING THAT SERIOUSLY AFFECTED YOU: LOSS OF FAMILY, FRIEND, PET, DIVORCE, RECENT MOVE, UNEMPLOYMENT, ILLNESS, NEW JOB, ACCIDENT, ETC.....

DO YOU WORK WITH CHEMICALS OR TOXINS ?_____
OCCUPATION?_____