The Wellness Centre
of Baton Rouge

CLIENT PROFILE

Name_____ Occupation_____

Address_____

City_____ State_____ Zip Code_____

Cell Phone_____ Evening Phone_____

Email_____ Birthdate_____

Whom May We Thank for Referring You to us: _____

THE MOST IMPORTANT QUESTIONS:

1. Before we dive into the details of your health history, what are the 3 most important things we can help you with to improve your health and quality of life?

   A. _____

   B. _____

   C. _____

2. If you have tried therapies to help these issues in the past, what was successful? What wasn't?_____

3. On a scale of 1-10, how important is your health to you? Scale is: 1 = low, 10 = highest importance

   1 2 3 4 5 6 7 8 9 10

4. On a scale of 1-10, how willing are you to make lifestyle changes to gain greater health? Please circle... 1 2 3 4 5 6 7 8 9 10

YOUR CURRENT NUTRIENT REGIMEN

Please list the supplements you take on a regular basis: _____

_____

_____

MEDICATIONS

Please list any medications you are currently taking:_____

_____

DETOXIFY

TOXIC BURDEN

Please check off the symptoms you are regularly experiencing under each category heading and please check off any toxin groups which you are concerned about and if you have a reason, please list why...

BACTERIA

- [ ] Yellow/green discharge
- [ ] Fever gets worse with time
- [ ] Symptoms persist longer than 10-14 days
- [ ] Focal area of illness (sinuses, lungs, throat, etc…)

[ ] I am concerned about this group.
Why? _____

VIRUSES

- [ ] Clear discharge
- [ ] Low-grade fevers/chills
- [ ] History of chronic viral infection (EBV, HPV, Herpes, HIV, etc…)
- [ ] Body-wide aches/fatigue

[ ] I am concerned about this group.
Why? _____

MOLD/FUNGUS

- [ ] Frequent antibiotic usage
- [ ] Fungal rashes/eczema/psoriasis/yeast infections
- [ ] White, coated tongue
- [ ] Strong cravings for sugars and starches

[ ] I am concerned about this group.
Why? _____

LYME

- [ ] History of tick bite
- [ ] Neurological symptoms/confusion/heavy feeling in head
- [ ] Diagnosis of Lyme, MS, Lupus, Autism
- [ ] Excruciating joint pain, non-related to arthritis

[ ] I am concerned about this group.
Why? _____

HEAVY METALS

- [ ] Currently have silver fillings/recently had them removed
- [ ] Exposure through vaccinations/job
- [ ] Memory difficulties
- [ ] Tremors/Alzheimer's/Parkinson's

[ ] I am concerned about this group.
Why? _____

CHEMICALS

- [ ] Chemical exposure at home or work (hair salon, nail salon, etc…)
- [ ] Use commercial cleaning products
- [ ] Use commercial personal care products
- [ ] Currently smoke or exposed to smoke

[ ] I am concerned about this group.
Why? _____

PESTICIDES

- [ ] Eat non-organic produce and animal products
- [ ] Use fertilizer and pesticides on yard
- [ ] Drink/bathe in unfiltered tap water
- [ ] Pesticide exposure through occupation

[ ] I am concerned about this group.
Why? _____

PARASITES

- [ ] History of digestive upset
- [ ] Bloating/gas
- [ ] Itching skin, especially at night
- [ ] Irritable bowel/Crohn's/Celiac

[ ] I am concerned about this group.
Why? _____

NOURISH

Our next step is to find out how we can better nourish your body through nutrition & lifestyle.

DIGESTION

You are not what you eat…you are what you DIGEST! Please check the symptoms which you experience:

- ☐ Acid reflux/heartburn
- ☐ Belching after fatty meals
- ☐ Bloating after eating carbs/sugar
- ☐ Constipation or bowel movt less than 1x/day
- ☐ General indigestion after eating
- ☐ Hard, small, or stringy stools
- ☐ I am 25+ years old and want to optimize my digestion
- ☐ Mild sensitivity to gluten and/or dairy
- ☐ Stools float or light in color
- ☐ Took antibiotics without probiotics
- ☐ Ulcer or pain after eating
- ☐ Other: _____

THE BASICS

1. **SLEEP**
   How many hours do you sleep at night? _____ Do you feel refreshed when you wake up? ☐ **Y** ☐ **N**

   What time do you go to sleep? _____ Is your room completely darkened? ☐ **Y** ☐ **N**

   If it is less than ideal, how would you describe your sleep?

   _____

2. **EXERCISE**
   What kind of exercise do you do? _____

   How often? _____

3. **SUNLIGHT**
   Do you get outside daily for at least 20 minutes with no sunscreen? ☐ **Y** ☐ **N**

4. **HYDRATION**
   How many glasses of water do you drink daily? _____

   Do you drink any of these diuretics on a daily basis? ☐ **Coffee** ☐ **Caffeinated Drinks** ☐ **Alcohol**

5. **FRUITS & VEGGIES**
   How many servings of fruits and vegetables do you get on a daily basis *(1 serving = 1 piece of fruit or 1/2 cup)*

   ☐ **None** ☐ **1 to 2** ☐ **3 to 4** ☐ **5+**

WOMEN-ONLY

Are you currently pregnant or breastfeeding? ☐ **Y** ☐ **N** Do you get a monthly period? ☐ **Y** ☐ **N**

Are you experiencing any of the following hormonal symptoms?

- ☐ Hotflashes, night sweats
- ☐ Drop in libido
- ☐ Difficulty losing weight
- ☐ Insomnia
- ☐ Painful periods, cramping
- ☐ Cysts/fibroids
- ☐ PMS
- ☐ Other: _____

Have you struggled with fertility/miscarriage? ☐ **Y** ☐ **N** Have you had a hysterectomy? ☐ **Y** ☐ **N**

Do you take birth-control pills/hormones? ☐ **Y** ☐ **N** List: _____

How many children have you delivered? _____ Have you had an episiotomy or C-section? ☐ **Y** ☐ **N**

MEN-ONLY

Have you experienced a drop in muscular strength, drive, or libido? ☐ **Y** ☐ **N**

Do you have difficulty urinating or have an enlarged prostate? ☐ **Y** ☐ **N**

SYMPTOMS YOU MAY EXPERIENCE

Please check the symptoms which you are experiencing regularly…

- ☐ Headaches
- ☐ Weakness
- ☐ Arthritis, stiff & painful joints
- ☐ Shy, insecure
- ☐ Losing weight, underweight
- ☐ Insomnia, wake up at night
- ☐ Generalized aches, pains
- ☐ Very sensitive to cold
- ☐ Nail biting
- ☐ Dry, rough, flaky skin
- ☐ Worried
- ☐ Fainting spells, dizziness
- ☐ Heart palpitations
- ☐ Constipation, intestinal gas, bloating
- ☐ Dry, sore throat, dry eyes
- ☐ Agitated mind, difficulty concentrating
- ☐ Anxious, fearful, nervous
- ☐ Fatigue, poor stamina
- ☐ Antsy or hyperactive behavior
- ☐ Low back pain or menstrual cramps
- ☐ Tired, yet can't relax
- ☐ Indecisive

Total # of Checks:_____

- ☐ Flushed face
- ☐ Acidity, heartburn, ulcer
- ☐ Acne, rosacea
- ☐ Angry, irritable
- ☐ Argumentative, bossy
- ☐ Bad breath, bitter tase in mouth
- ☐ Blood-shot eyes
- ☐ Boils
- ☐ Bossy, controlling
- ☐ Critical of self & others
- ☐ Diarrhea, loose stools
- ☐ Excessive hunger or thirst
- ☐ Fevers, night sweats
- ☐ Disturbing, violent dreams
- ☐ Frustrated, willful
- ☐ Hostile, destructive
- ☐ Impatient
- ☐ Inflammation
- ☐ Skin rashes
- ☐ Sour body odor
- ☐ Very sensitive to heat, hot flashes
- ☐ Weakness due to low blood sugar

Total # of Checks:_____

- ☐ Allergies, hay fever
- ☐ Apathetic, no ambition
- ☐ Body & limbs feel heavy, swollen
- ☐ Clingy, hanging on to people/ideas
- ☐ Depressed, sad, overly sensitive
- ☐ Diabetes
- ☐ Greedy, possessive, materialistic
- ☐ Groggy all day
- ☐ High cholesterol
- ☐ Mucus & congestion in sinuses/nose
- ☐ Mucus & congestion in throat/chest
- ☐ Nausea
- ☐ Pale, cool, clammy skin
- ☐ Procrastinating, lethargy
- ☐ Sleeping too much
- ☐ Slow to comprehend
- ☐ Slow to react
- ☐ Sluggish, digestion, mucus in stool
- ☐ Sluggish, dull thinking
- ☐ Very tired in morning, hard to get up
- ☐ Water retention, swelling
- ☐ Weight gain, obesity

Total # of Checks:_____

MEDICAL HISTORY check all that apply

- ☐ Heart conditions
- ☐ Sinus/Allergies
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Cancer/Tumors
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Neck Issues/Surgery
- ☐ Thyroid Issues
- ☐ Digestive Disorders
- ☐ Arthritis
- ☐ Headaches/Migraines
- ☐ Back/Muscle Pain
- ☐ Autoimmune (MS, Lupus, RA)