New Client Health & Wellness Paper Work

asana WELLNESS CENTER

Name: _____

Date: _____ D.O.B.:_____

Address:_____

City:_____St:_____Zip:_____

Home Phone:_____ Cell Phone:_____

E-mail Address:_____@_____

Emergency Contact:_____Phone:_____

How did you hear about us (i.e. website, friends name, newspaper, ad, facebook, etc)?

_____

What brought you to Asana Wellness today? _____

_____

Check all or additional areas of interest or concern:

☐Weight Loss	☐Hormone Balancing	☐Nutritional Counseling	☐ Detox	☐Food Sensitivities	☐Stress Reduction
☐Personal Training	☐ Cardiac Rehab	☐GI/ Stomach Issues	☐ Immune Issues	☐ Increase Energy	☐Reduce Medication Dependency
☐Meal Plans	☐Reduce Cholesterol/ BP	☐Increase Mental Clarity/ Focus	☐ Increase Strength/ Flexibility	☐Gluten Free Programs	☐General Fitness/ Wellness

Have you had any of the following health conditions in the past or present?

Cancer	□	Diabetes	□	Heart Disease/ Stroke	□
Headaches	□	Hepatitis	□	High/Low Blood Pressure	□
Autoimmune	□	Thyroid	□	HIV/AIDS	□
Insomnia	□	Arthritis	□	Asthma	□
Skin diseases	□	GERD	□	Ringing in Ears	□

Cardio-Metabolic

Please rate the following on a 0 - 10 scale with **10 Being Always** and **0 Being Never**.

Heart Palpitations/ Irregular Heart Beat _____	Chest Pain/ Tightness / Shortness of Breath _____	Swelling in Ankles _____
High Blood Pressure _____	High Cholesterol _____	Smoking _____
Numbness/Tingling: hands or feet _____	Anxious Feeling/ Anxiety _____	**Total Points** _____

Hormone

Please rate the following on a 0 - 10 scale with **10 Always** and **0 Being Never**.

Decreased Libido _____	Fatigue/ Low Energy _____	Brain Fog/ Forgetfulness _____
Difficulty Sleeping _____	Hair Loss/ Thinning _____	Depression/ Mood Swings _____
Difficulty Losing Weight _____	Craving Sweet/ Salty Foods_____	**Total Points** _____

Nutrition

Please rate the following on a 0 - 10 scale with **10 Always** and **0 Being Never**.

Skip Meals _____	Gas/ Bloating/ Reflux_____	Constipation/Diarrhea_____
GI Upset with Certain Foods_____	Eat Out _____	Eat Fried Foods _____
Drink Sodas/ Energy Drinks _____	Eat Breads/ Pastas/ Cereals_____	Drink Alcohol/ Caffeine _____
Eat Desserts/ Snacks _____		**Total Points** _____

Fitness

Please rate the following on a 0 - 10 scale with **10 Always** and **0 Being Never**.

Rate your frequency of exercise. _____	Rate your cardiovascular capacity. _____	Rate your muscular capacity. _____
Rate how flexible you are _____	Rate when you exercise your intensity/exertion level _____	Rate your positive feelings about exercise. _____
Do You Belong to a Gym? Y/N	Are You Interested in Working Out? Y/N	**Total Points** _____

Environment

Please rate the following on a 0 - 10 scale with **10 Always** and **0 Being Never**.

Headaches _____	Are You Sensitive to smells? _____	Tired/Hard to Get out of Bed _____
Work w/: Paint, Insecticides, Chemicals, Construction Materials, _____	Exposure to or live in area with mold _____	Consume conventionally grown produce (non organic) _____
Burning in Eyes/ Ears/ Nose/ Throat/ Lungs _____	Confusion/ Memory Problems _____	Do you smoke or have exposure to second hand smoke? _____
Problems with Balance/ Coordination _____		**Total Points** _____

Well-being

Please rate the following on a 0 - 10 scale with **10 Always** and **0 Being Never**.

I feel useful. _____	I deal well with problems. _____	I am interested in other people. _____
I feel loved. _____	I feel good about myself. _____	I feel close to others_____
I lead a purposeful and meaningful life. _____	I am able to make my mind up about things. _____	I feel optimistic about the future. _____
I am engaged and interested in my daily activities. _____		**Total Points** _____

Do you have a specific health or wellness issue that you want help with? _____

If so how is this issue specifically impacting your life now? (ex tired, impacting work, marriage, etc) _____

_____

If this issue were no longer an issue, what would your life be like? _____

_____

What if anything have you tried that did not work to resolve this issue? _____

_____

What if anything do you believe you need so you can overcome this issue and reach your desired results?

_____

_____

What is the Outcome or Result that is most important for you to receive? _____

_____

On a scale from 1-10 (10 being the most) how important is it to you to resolve this issue? _____

I understand, have read and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that Asana Wellness does not diagnose or treat my medical conditions. I am seeking out their help to identify my predictive risk factors that can increase my chance of chronic disease. I understand that by identifying my risk factors they will then recommend targeted lifestyle support that if acted upon, can help me reduce my risk of disease and increase my ability to be healthier.

While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client, therefore no guarantee can be given. I also understand that any recommendations made are up to me to choose to accept and engage in for optimal results to occur.

I understand that if I withhold information or provide misinformation, incomplete results or recommendations can occur from treatments received. I am aware that it is my responsibility to inform the Asana Wellness team of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Asana Wellness, LLC from liability and assume full responsibility thereof.

Client signature:_____ Date:_____