Wellness 1st Integrative Medical Center, LLC

Initial Consultation/ Wellness Evaluation (Please Be Honest & Fill Out Completely)

Name: _____ Age: _____ Date: _____

Main Complaints/ Unwanted Health Problems:

1) _____ 2) _____

3) _____ 4) _____

How long have you been suffering with this/these problem/s?: _____

Any other complaints/ issues: _____

_____

Would you like improvement with any of the following?:

☐ Digestion: Reflux, Gas, Constipation, Diarrhea ☐ Sense of Well Being

☐ Sleep: Falling asleep or staying asleep ☐ Energy ☐ Mental Clarity, Memory

What have you tried doing to resolve this problem that Did Not work?

_____

Have you become discouraged or stressed about handling this problem?

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this/these problem/s may have started?

_____

What effect does this have on your body functions? _____

_____

Are you here visiting us to:

a) Resolve my immediate problem b) Lifestyle program for optimized living c) Both

d) Other: _____

How have you taken care of your health in the past?

Medications	Holistic
Routine medical	Vitamins
Exercise	Chiropractic
Diet and Nutrition	Other: _____

How did the previous methods work for you? _____

What are you afraid this might affect if no change is made? Please Circle

Job	Marriage	Freedom	Future Abilities	Kids	Sleep
Finances	Time	Relationships	Life		

What health conditions you are afraid this might turn into? Please Circle

Arthritis	Cancer	Depression	Diabetes	Diminished Future Abilities
Heart disease	Surgery	Stress	Weight gain	Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is NOT taken care of? Please be specific

_____
_____

What would be different or better without this problem? Please Circle:

Confidence	Family	Diminished stress	Healthy	Self esteem	Sleep
Outlook	Work	More Energy			

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____
_____
_____
_____
_____
_____

Are there potential barriers that would prevent these goals from happening?

_____
_____

How can we eliminate or prevent these potential barriers?

_____
_____
_____

Tell me your strengths that will enable you to accomplish your goals?

_____
_____
_____

How long have you been thinking about getting rid of your health condition/s? ___days ____months ____years

On a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?
_____ Are you ready to get started today?

Do you believe your health condition/s: Check One

_____ Have been going on for too long & may require a lot/ some work?
_____ Have been going on for a short time & may require a little work?
_____ Have just come about and may require minor work?
_____ I'm happy with my health condition and it doesn't need any work?

Thank You & God Bless!