**WELLNESS CENTRE OF MARQUETTE**

***INITIAL CLIENT HISTORY***

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_ Blood Type \_\_\_\_\_\_\_\_\_**

**A+/A-/B+/B-/AB/O+/O-**

**Current Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

**1. Past Health Issues 2. Current Health Issues**

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**3. Surgeries**

**Type/Diagnosis Date of Surgery (*approximately*)**

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**4. Medications**

**Name Name Date Started Date Finished Currently Taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

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**5. Women Only - Menstrual Related Symptoms (*check all that apply*):**

**\_\_\_\_\_ heavy bleeding \_\_\_\_\_ clotting \_\_\_\_\_ menstrual cramps \_\_\_\_ breast tenderness \_\_\_\_\_ mood swings/irritability**

**\_\_\_\_\_ fluid retention \_\_\_\_\_ sweet cravings**

**Type *(if any*) Birth Control used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past/Present (*please circle)***

6. **DIET**

**# and type of average protein serving’s daily (*eggs, meat, fish, chicken, turkey, nuts/seeds, beans*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**# average daily servings fresh fruits and vegetables \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**# average daily servings flour foods,(*i. e. bread, crackers, cookies, pretzels*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sweets - # times weekly \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*candy, cakes, cookies, pastries, ice cream*)**

**Beverages: Pop/Soda \_\_\_\_\_\_ Coffee/Tea \_\_\_\_\_\_\_\_ (*weekly servings*) Alcohol\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Average daily water intake: \_\_\_\_\_\_\_oz. Type of Water: \_\_\_\_\_\_\_ well \_\_\_\_\_ city/tap \_\_\_\_\_\_\_ filtered**

**(*type of filter used*)\_\_\_\_\_\_\_\_\_\_\_\_**

7. **EXERCISE**

**Type of exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # times per week\_\_\_\_\_\_ Total time spent weekly \_\_\_\_\_\_\_\_**

**(*i.e. walking/running/stretching*)**

**Continued on other side**

**8. CURRENT HEALTH SYMPTOMS *(check all that apply)***

**\_\_\_\_\_ Hormonal \_\_\_\_\_Libido \_\_\_\_\_Hot flashes \_\_\_\_\_Night sweats**

**\_\_\_\_\_ Low Energy \_\_\_\_\_Lethargy \_\_\_\_\_Overtired \_\_\_\_\_Fatigue**

**\_\_\_\_\_ Depression \_\_\_\_\_Mood swings \_\_\_\_\_Emotional \_\_\_\_\_Irritability**

**\_\_\_\_\_ Allergies \_\_\_\_\_Sneezing \_\_\_\_\_Sinus \_\_\_\_\_Acid Reflux**

**\_\_\_\_\_ Digestive \_\_\_\_\_Diarrhea \_\_\_\_\_Constipation \_\_\_\_\_Heartburn**

**\_\_\_\_\_ Sleep disturbances \_\_\_\_\_Insomnia \_\_\_\_\_Night time urination \_\_\_\_\_PMS**

**\_\_\_\_\_ Skin issues \_\_\_\_\_Psoriasis \_\_\_\_\_Rashes \_\_\_\_\_Eczema**

**\_\_\_\_\_ Other \_\_\_\_\_Headaches \_\_\_\_\_Vision \_\_\_\_\_Visual Disturbances**

**9. STRESS LEVEL (*Personal and work related*) Circle your choice**

**Mild Moderate Severe**

3 Day Diet History

|  |  |  |  |
| --- | --- | --- | --- |
| Meal | Day 1 | Day 2 | Day 3 |
| Breakfast |  |  |  |
| Lunch |  |  |  |
| Dinner |  |  |  |
| Snacks |  |  |  |
| Water/Tea (ounces) |  |  |  |