PERSONAL WELLNESS ASSESSMENT

The information presented in this form is intended to help provide a profile of your past and present nutritional health. Please fill out completely to the best of your knowledge. We will review this form in your consultation.

Personal Information

Name_____ Date_____
Street Address_____ Birthdate ____/____/____
City_____State_____Zip Code_____ Male___ Female___
Telephone #_____Cell #_____ Height ____ft____in
E-mail_____ Weight _____lbs

Current Occupation_____Employer_____
Cholesterol_____ Date of test_____ Blood Pressure_____/_____ Date of test_____

Who were you referred by? _____

What are your health concerns and how long have they been an issue? Please give as many details as possible.
1._____
2._____
3._____

What medications, medical procedures, supplements or therapies have you previously tried for your condition? Which were helpful and which were not effective?

Please list:	Helpful	Ineffective
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

On a scale of 1-10, how willing are you to make lifestyle changes to gain greater health?
Scale is: 1=I don't want to change anything, 5=I will make moderate changes, 10=I will do anything it takes!

1 2 3 4 5 6 7 8 9 10

If you are under a doctor's care for any conditions, please list them along with any medications or therapies you are using:

Medical Condition	Medications or therapies
_____	_____, _____, _____
_____	_____, _____, _____
_____	_____, _____, _____

List any allergies you have:_____

Indicate any surgeries, accidents or other trauma you have had in the past:
_____
_____

What nutritional supplements are you currently taking?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Lifestyle Practices

Diet

1. Please list the foods you commonly eat for each meal. Don't worry about looking good here...we will start where you are at and move from there. It is helpful to get a realistic look at your day.
   Breakfast (typical time eaten:_____)_____
   _____
   Lunch (typical time eaten:_____)_____
   _____
   Dinner (typical time eaten:_____)_____
   _____
   Snack (typical time eaten:_____) _____
   _____

2. What types of food do you eat most often? __fresh __canned __fast food __frozen __fried

3. How often do you eat the following foods: *1= once or more daily, 2= weekly, 3= occasionally, 4=never*

__artificial sweeteners	__lunch meats	__dairy	__breads, crackers, pasta, etc.
__fresh fruits	__red meat	__white meat	__fish, seafood
__fresh vegetables	__eggs	__dessert	__candy bars, candy, etc.

4. List any foods you are allergic to:_____

5. Check the statements(s) that best describe(s) your typical eating experience:
   __I eat quickly and often do not chew my food thoroughly. __I chew my food slowly and relax.
   __I eat most meals while standing, driving or attending to other matters. __I don't eat 3 meals per day.

6. Check the word(s) that best describe(s) your experience 30-60 minutes after eating:
   __bloated __gas __diarrhea/cramping __headache __ tired __congested __burning sensation
   __filled/satisfied __itching/hives __wheezing __nausea/vomiting __pain (location)_____

7. Most foods I eat cause me to feel: __energized __guilty __sick __tired __uncomfortable

8. Which types of foods do you crave frequently?
   __salty __sweet __protein __chocolate __caffeine __carbohydrates __fried __alcohol

9. Please complete this statement: No meal is complete without:_____

Fluid Intake

1. Describe the type of water that you drink most frequently:
   __fluoridated __well __cistern __bottled __distilled __reverse-osmosis __Kangan

2. Check the phrase that best describes your drinking water habits :
   __I drink water throughout the day. __I rarely drink water because I am rarely thirsty.
   __I drink water infrequently. __I drink water frequently because I am always thirsty.

3. Approximately how many glasses (8 oz.) of water do you drink daily?_____
4. Check the type(s) of beverages you drink daily in addition to water:
__coffee __juice __diet drinks __tea (hot/cold) __milk __soda __sports drinks __non-dairy __ caffeinated
5. How many ounces of the above beverages do you consume daily?_____ Weekly?_____
6. How many alcoholic drinks do you consume each week?_____

Dieting

1. Have you ever dieted? __Yes __No

2. Check the phrase the best describe(s) your dieting experiences:
__I have dieted off and on my entire life. __My diet programs have been successful.
__I lose a few pounds only to gain them back.

3. When you gain weight, in what area(s) do you generally notice it?_____

Exercise

1. How often do you exercise?_____
2. How many minutes do you exercise?_____
3. What do you do for exercise?_____

Body Systems

Please check all that apply.

Respiratory/Sinus /13
__allergies
__asthma or wheezing
__sore throat frequently
__sinus infections
__frequent cough
__bronchial infections
__phlegm in throat
__food sensitivities
__constipation/diarrhea
__congested air passages
__itchy nose/ears
__sinus headaches/congestion
__swollen lymph glands

Liver/Gallbladder /13
__pain between should blades
__history of gallstones
__crave fatty or greasy foods
__frequent skin rashes
__stools light-colored or float
__bad breath (halitosis) or body odor
__abdominal pain/discomfort
__difficulty getting to sleep
__fatigue or low energy
__food allergies
__constipation/diarrhea
__headaches/migraines
__varicose veins

Structural /12
__joint stiffness upon arising
__brittle bones or fingernails
__history of joint injuries
__muscle cramps at night
__osteoporosis
__joint pain, arthritis or gout
__bulging/compressed disks
__tendonitis/bursitis
__feet hurt in the morning
__dry skin
__frequent backaches
__weak legs, knees or ankles

Intestinal /13
__abdominal pain/discomfort
__bad breath or body odor
__colitis or crohns
__constipation or dry stool
__excess mucus production
__fatigue or low energy
__intestinal gas or bloating
__loose stools or diarrhea
__muddled thinking, confusion, mental sluggishness
__sinus congestion
__headaches
__swollen lymph glands
__irritable bowel syndrome

Digestion /13
__poor/excessive appetite
__pale complexion or anemia
__strong thirst
__nausea/vomiting
__acid reflux/heartburn
__ulcers
__gas/bloating
__diarrhea/constipation
__abdominal pain/discomfort
__anxiety, nervousness, tension
__cravings for sugar
__food allergies
__food sits heavy on stomach after eating
__general weakness or chronic illness

Urinary /13
__burning/painful urination
__dark circles or puffiness under eyes
__frequent backache
__frequent urinary tract infections
__elevated blood pressure
__scant/excessive urination
__incontinence
__joint pain, arthritis, gout
__kidney stones
__osteoporosis
__water retention
__weak legs, knees or ankles

Immune /13
__antibiotic use in the last year
__frequent stuffy/runny nose
__chronic fatigue or low energy
__craving sweets or chocolate
__bronchial infections
__skin problems
__nail fungus
__muscular soreness
__food allergies
__frequent infections
__general weakness or chronic illness
__itchy nose/ears
__swollen lymph glands

Cardiovascular /13
__high/low blood pressure
__irregular heartbeat
__heavy or difficult breathing
__bruise easily
__dizziness/light headedness
__swollen ankles
__ringing/pounding in ears
__varicose veins
__numbness or coldness in hands or feet
__craving fats
__fatigue or low energy
__diagnosis of any heart problems
__wounds won't heal in extremities

Stress/Anxiety/Depression /13
__apprehension/nervousness
__depression/hopelessness
__irritability
__addictions
__panic attacks or anxiety
__inability to concentrate/forgetfulness
__feeling overwhelmed
__irritable bowel
__difficulty going to sleep
__fatigue or low energy
__headaches/migraines
__restless dreams or nightmares
__waking up frequently at night

Detoxification

Elimination History/Habits

1. How many bowel movements do you have daily?_____
2. If bowel movements do not occur regularly, how many do you have weekly?_____
3. Do you have a history of diarrhea? __Yes __No Constipation? __Yes __No
4. Do you frequently have gas? __Yes __No
5. Does gas cause you pain, bloating, and discomfort? __Yes __No
6. Which words describe(s) your typical bowel movements?
   __loose and easy to pass __hard and difficult to pass __bloody __floating __frequently green
   __often black __containing mucus __frequent diarrhea __preceded/followed by cramping or pain
7. Do you frequently have hemorrhoids? __Yes __No

8. Approximately how many times do you urinate daily?_____
9. Choose the word(s) that best describe(s) your urine:
   __contains blood __looks like clear water __has a strong odor __contains particles or sediment

10. Choose the word(s) that best describe(s) your urination processes/habits:
__cramping __urgency __easy and complete flow of urine __burning/pain __urinate frequently at night
__incontinence __unable to empty bladder fully __flank pain before/during/after
11. Do you have a history of urinary tract infections? __Yes __No

12. Which best describe(s) how your body sweats?
__always __occasionally __only when I exercise __when I am nervous __rarely (even when it's hot outside)
13. Does your sweat have an unpleasant odor? __Yes __No
14. Do you regularly use a(n) __antiperspirant __deodorant?

15. Do you ever have any unexplained or unusual swelling, inflammation or fluid retention?
__Yes __No __occasionally __only premenstrual
16. If applicable, list area(s) of swelling/inflammation/fluid retention:_____

Please check all that apply.

Parasites /14

__yeast infections
__antibiotics in the past 5 years
__nausea
__indigestion, heartburn, GERD
__joint & muscle pain
__fatigue
__frequent ear/nose/throat infections
__auto-immune disease
__rashes/hives/psoriasis/boils/acne
__swelling in lymph nodes around neck
__anemia
__hypoglycemia (low blood sugar)
__irritable bowel syndrome
__diverticulitis/colitis/Crohns disease
__I have lived on a tropical island
__I have visited a foreign country in the past 5 years

Environmental Chemicals /12

__I have _____(number) amalgam fillings.
__I have _____(number) root canals.
__New furniture or cabinetry in home or workplace
__Home or workplace located close to excessive air, water or environmental pollution
__Frequent exposed to toxic or poisonous materials
__Home or workplace has recently been painted
__Presently smoke or have smoked in the past
__Frequently exposed to second-hand smoke
__Have been exposed to radiation
__Toothpaste contains flouride
__History of drug addiction
__Vaccinated as a child

Viral /12

__frequent viral infections
__recurrent canker sores
__recurrent warts
__history of polio
__history of mononucleosis
__Herpes Simplex I or Genital Herpes
__history of infectious
__Frequent cold or flu symptoms
__frequent muscular aching/chills
__frequent exposure to ill individuals
__history of shingles (Herpes Zoster)
__history of tonsillitis or croup

Yeast/Fungal /14

__Indigestion after eating fruits & sweets
__bloating after meals
__chronic sinus problems
__itchy skin/scalp
__frequent antibiotic usage
__cravings for sweets
__cloudy thinking/mental fog
__history of eczema/psoriasis/dandruff
__constipation/diarrhea
__consume a lot of sugar
__vaginal discharge
__recurrent urinary tract infection
__allergy/sensitivity to the fermented/moldy
__rectal burning or itching

Heavy Metals /14

__metallic taste in mouth
__loose teeth
__chronic headaches
__arthritis/pain in joints
__mouth ulcers
__swollen tongue
__unexplained skin rashes
__anxiety, depression
__frequent exposure to fertilizers
__frequent ingestions of seafood
__tremors or twitching
__autoimmune disease
__bone loss around teeth
__frequent exposure to lead-based paints/solvents/chemicals

Bacterial /11
__frequent bacterial infections
__chronic sinusitis
__dental abscess
__frequent exposure to ill individuals
__history of staph or stress infections
__frequent ear infections
__sinus discomfort or facial bone pain
__unusual skin rash/eczema
__frequent discolored mucus/nasal secretions
__history of tuberculosis
__bitten by a deer tick

Glandular Systems

Stress

1. Are you under stress? __Yes __No If so, explain:_____
2. I respond to stress by: __exploding __lashing out __holding it in __becoming anxious or nervous __eating
3. My daily stress level is: __low __moderate __high __very high __I don't get stressed daily

4. How many hours of sleep do you get each night on average?_____
5. Which statement(s) best describe(s) your sleep? __restless __deep __light __hard to fall asleep
   __wake up frequently at night (how often?_____ what time usually?_____)

6. What is your energy level like? __extremely high __high __moderate __low __extremely low

Please check all that apply.

Adrenal /13
__cravings for salt/sweets
__constant or chronic fatigue
__headaches/migraines
__low blood pressure
__chronic back pain
__panic attacks
__nervousness
__muscular weakness
__extreme sensitivity to odors/noise
__stress-filled lifestyle
__clenching or grinding of teeth at night
__blood sugar disturbances
__tendency to gain weight in the waist (love handles)

Thyroid /13
__cold hands and feet
__dry/brittle hair
__fatigue
__tired in AM and energetic in PM
__slow or slurred speech
__muscle cramps, especially at night
__frequently constipated
__PMS or menstrual difficulties
__hair loss
__cracks in bottom of your heels
__low libido
__swelling of hands and face
__low body temperature

Blood Sugar /11
__eat when nervous
__excessive appetite
__hungry between meals
__irritable before meals
__get "shaky" if hungry
__"lightheaded" if meals are delayed
__heart palpitations if meals are missed
__afternoon headaches
__awaken after a few hours of sleep
__crave sweets or coffee
__afternoon fatigue

Female ED/EL /11
__tender breasts
__anxious/nervous feelings
__weight gain in hip/waist area
__menstrual bleeding changes
__water retention
__uterine fibroids
__fibrocystic breasts
__mood swings/irritability
__cold body temperature
__headaches
__infertility

Female Menopause /11
__hot flashes
__foggy thinking/memory lapses
__heart palpitations
__night sweats
__bone loss
__increase in facial/body hair
__increased urinary urge/incontinence
__vaginal dryness
__trouble falling asleep or staying asleep
__weight gain around waist
__depression

Pituitary/Hypothalamus **/10**
__failing memory
__low blood pressure
__increased sex drive
__splitting headaches
__decreased sugar tolerance
__abnormal thirst
__bloating of abdomen
__tendency toward ulcers
__weight around hips or waist
__sugar cravings

Male Health **/10**
__enlarged prostate
__elevated PSA count
__difficult or dribbling urination
__lack of motivation/energy
__depression
__leg nervousness at night
__diminished sex drive
__erectile dysfunction
__migrating aches and pains
__feeling of incomplete bowel evacuation

Informed Consent

Thank you for allowing us to assist in your quest for good health. We understand that you have the opportunity to choose from a variety of health care practitioners, wellness philosophies and forms of analysis in your quest for optimal health. Having chosen our services, we will conscientiously work to do our best to help you achieve your wellness goals. It is also important that you understand who we are, what we believe and what we do.

Who we are not:

- We have no licensed physicians or surgeons on staff.
- We do not willfully diagnose or treat diseases or medical conditions, nor do we conduct surgery or perform any invasive bodily procedures.
- We do not prescribe or administer legend drugs or controlled substances to another person.
- We do not recommend discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner.

Who we are:

Our staff includes

- Three Doctors of Naturopathy (N.D.s - licensing not required by the State of Indiana)
- Two Masters of Herbology
- We have been practicing natural health since 1979 (over 29 years) and are involved in continuing wellness education and training.

What we believe about health:

- God is the Creator of the universe, which includes all of mankind and foods designed to sustain us.
- God has established certain spiritual, physical and dietary laws laws in the universe that bring forth blessing when followed and harm when they are not.
- Because of mans propensity to do what is wrong, God has provided His authoritative Word, the Bible, to instruct us in truth and righteousness and contains many dietary and general health principles to help guide our decisions and practices that will promote wellness.
- Modern science and complimentary/alternative health practices have done much to help man achieve better health, but must be adjusted to conform to God's Word regarding health.

I have read and understand the above disclosure. I have voluntarily submitted all the accompanying information, and have not been coerced in any manner. I acknowledge that I assume full responsibility for my choices regarding health care , wellness philosophies, and my decision to participate in any services, assessments or consultations provided by A Harvest of Health. I do not hold A Harvest of Health, Nutrition &Wellness Center, or any associated employee or person, liable in any way for recommendations or suggestions made on mine, or my family's behalf. I understand that any information provided is intended for educational purposes only and is not to be used to diagnose, treat or cure any disease. I further understand that the primary emphasis of this establishment is on total wellness and good health practices, not on specific treatment of illness or disease. I am seeking education advice, and am not visiting on a mission of entrapment or as a representative of any state or local authority. *Note: If you have a serious health problem, please consult a competent health care practitioner.*

Signature (ink)_____Date_____

Beloved, I wish above all things that thou mayest prosper and be in health, even as thy soul prospereth. ~ III John 2