



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
- | | | | |
|------------------------------------------------|--------------------------------------|-------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> artificial sweeteners | <input type="checkbox"/> lunch meats | <input type="checkbox"/> dairy | <input type="checkbox"/> breads, crackers, pasta, etc. |
| <input type="checkbox"/> fresh fruits | <input type="checkbox"/> red meat | <input type="checkbox"/> white meat | <input type="checkbox"/> fish, seafood |
| <input type="checkbox"/> fresh vegetables | <input type="checkbox"/> eggs | <input type="checkbox"/> dessert | <input type="checkbox"/> 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:
- | | |
|--------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> I eat quickly and often do not chew my food thoroughly. | <input type="checkbox"/> I chew my food slowly and relax. |
| <input type="checkbox"/> I eat most meals while standing, driving or attending to other matters. | <input type="checkbox"/> I don't eat 3 meals per day. |
6. Check the word(s) that best describe(s) your experience 30-60 minutes after eating:
- | | | | | | | |
|-------------------------------------------|----------------------------------------|--------------------------------------------|------------------------------------------|------------------------------------------|------------------------------------|--------------------------------------------|
| <input type="checkbox"/> bloated | <input type="checkbox"/> gas | <input type="checkbox"/> diarrhea/cramping | <input type="checkbox"/> headache | <input type="checkbox"/> tired | <input type="checkbox"/> congested | <input type="checkbox"/> burning sensation |
| <input type="checkbox"/> filled/satisfied | <input type="checkbox"/> itching/hives | <input type="checkbox"/> wheezing | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> 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?
- | | | | | | | | |
|--------------------------------|--------------------------------|----------------------------------|------------------------------------|-----------------------------------|----------------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> salty | <input type="checkbox"/> sweet | <input type="checkbox"/> protein | <input type="checkbox"/> chocolate | <input type="checkbox"/> caffeine | <input type="checkbox"/> carbohydrates | <input type="checkbox"/> fried | <input type="checkbox"/> alcohol |
|--------------------------------|--------------------------------|----------------------------------|------------------------------------|-----------------------------------|----------------------------------------|--------------------------------|----------------------------------|
9. Please complete this statement: No meal is complete without: _____

Fluid Intake

1. Describe the type of water that you drink most frequently:
- | | | | | | | |
|--------------------------------------|-------------------------------|----------------------------------|----------------------------------|------------------------------------|------------------------------------------|---------------------------------|
| <input type="checkbox"/> fluoridated | <input type="checkbox"/> well | <input type="checkbox"/> cistern | <input type="checkbox"/> bottled | <input type="checkbox"/> distilled | <input type="checkbox"/> reverse-osmosis | <input type="checkbox"/> Kangan |
|--------------------------------------|-------------------------------|----------------------------------|----------------------------------|------------------------------------|------------------------------------------|---------------------------------|
2. Check the phrase that best describes your drinking water habits :
- | | |
|------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> I drink water throughout the day. | <input type="checkbox"/> I rarely drink water because I am rarely thirsty. |
| <input type="checkbox"/> I drink water infrequently. | <input type="checkbox"/> 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 shoulder 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

- 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

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

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

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

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)

- 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

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

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

- 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

Blood Sugar

/11

- eat when nervous
- excessive appetite

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 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