WELLNESS WITH SUJATA
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Client Health Assessment Form

Contact Information:

Last Name:_____ First Name: _____ M.I. _____

Preferred Name: _____ Gender: ☐ M ☐ F Date of Birth: ___/____/_____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ (cell): _____ (work): _____

Is it okay to leave a voice message: ☐ Home ☐ Cell ☐ Work ☐ None

Email address: _____Is it okay to correspond with you by email? ☐ Yes ☐ No

*NOTE: Email is not a secure method of communication.

Emergency Contact: _____ Phone: _____

Healthcare Provider Information

Primary Care Physician: _____ Phone: _____

How did you hear about us? Please circle one and write the name:

Current Client: _____ Friend: _____

Doctor: _____ Advertisement: _____

Other: _____

Reason for Visit

Health concerns: Please list your main health concerns in order of importance.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

What do you believe is causing your most important health concerns:

_____

_____

What is your main reason for today's visit: _____

How long have you had this condition: _____

How does it impact your quality of life? _____

Have you seen a physician or other health practitioner about this? _____ When? _____

What was the diagnosis (if any)? _____

Describe and treatment you had and the results: _____

_____

_____

What aggravates this condition? _____

What improves this condition? _____

Please describe the current state of your physical health:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please describe the current state of your mental health/sense of well being

☐ Poor ☐ Fair ☐ Good ☐ Excellent

What are your overall goals for working with Wellness With Sujata?

_____

_____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (please circle)

1 2 3 4 5 6 7 8 9 10

Not committed moderate 100% committed

What behaviors or lifestyle habits do you currently engage in that you believe contribute to and support your health goals?

_____

_____

What behaviors or lifestyle habits do you currently engage in that you believe could be detrimental to your health goals? _____

_____

What potential obstacles do you anticipate that may interfere with adhering to any lifestyle plan we present?

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____

What do you LOVE to do? _____

Do you now or have you in the past, had a meditation or yoga practice? □Yes □ No
If yes, which type of yoga and/or meditation did you practice and for how long?

Are you interested in learning how meditation can improve your physiological & emotional health? □ Yes □ No

Are you interested in participating in a yoga class or in learning how to meditate? □ Yes □ No

Lifestyle Habits

Occupation: _____ Hours per week: _____

Relationship Status: □ Single □ Married □ Partnership □ Divorced □ Separated □Widowed

With whom do you live? □ Spouse □ Partner □ Parents □ Friends □ Children □ Alone □ Pets

Do you exercise regularly? □ Yes □ No

If yes, please describe:

Type of Exercise	Number of Days per Week	Duration of Exercise

Do you have any physical conditions that limit your ability or safety to exercise? □ Yes □ No

Please specify any restrictions or limitations to exercise:

Have you exercised in the past year? □ Yes □ No

How many hours do you usually sleep per night? _____ What time do you go to bed? _____

Please circle the level of stress you experience at home:

1 2 3 4 5 6 7 8 9 10

No stress Moderate Extremely stressed

Please circle level of stress you experience at the workplace:

1 2 3 4 5 6 7 8 9 10

No stress Moderate Extremely stressed

Eating habits and food intake

Do you use tobacco products?	Y N	How much, how often?
Do you use alcohol products?	Y N	How much, how often?
Do you use caffeine products? (Please circle type) Tea Coffee Energy drinks	Y N	How much, how often?
Do you drink carbonated beverage products? (please circle type) Diet soda regular soda	Y N	How much, how often?

Do you have regular eating habits? ☐ Yes ☐ No

Do you eat while engaged in other activities? ☐ Yes ☐ No

Do you eat more when under stress or feeling depressed? ☐ Yes ☐ No

Do you experience sudden drops in energy? ☐ Yes ☐ No If yes, when? _____

How do you rate your diet?

1 2 3 4 5 6 7 8 9 10

Poor relatively healthy extremely healthful

Please describe any current dietary restrictions you have (vegetarian, vegan, dairy free, gluten free, etc)

_____

Do you have any food allergies? ☐ Yes ☐ No If yes, please describe: _____

_____

What foods do you consume on a regular basis? _____

_____

What top five foods do you crave? _____

_____

What top five foods do you avoid? _____

_____

Do you snack during the day? ☐ Yes ☐ No If yes, what do you eat? _____

What time do you usually snack? _____

How many times during the week do you eat breakfast? _____ What time? _____

What is your typical breakfast? _____

How many times per week do you eat the following meals out per week?

_____ Breakfast _____ Lunch _____ Dinner

How many days do you eat: _____ Breakfast _____Lunch _____ Dinner

List restaurants you normally choose: _____

_____

Do you normally cook your own meals? ☐ Yes ☐ No How often? _____

Do you like to cook? ☐ Yes ☐ No

Where do you do most of your grocery shopping? _____

How would you describe most of your meals? ☐ Relaxed ☐Rushed ☐ In front of TV or Standing ☐ Seated at table ☐ In the car ☐ Alone ☐ With family and friends

Do you eat a wide variety of foods? ☐ Yes ☐ No ☐ Unsure

How often do you consume sugar? ☐ Daily ☐ 3-4 times per week ☐ Occasionally ☐ Seldom/Never

Allergies

Please list any allergies you have to medications, environment and food. What is your reaction?

Allergen	Reaction
_____	_____
_____	_____
_____	_____

Client Health History

Height: _____ Weight: (Current) _____ (Last Year)_____ (Ideal) _____ (Highest weight) _____

Have you recently lost/gained weight: ☐ Yes ☐ No How much? _____

Was this an intentional change? ☐ Yes ☐ No

Do you weight yourself? ☐ Yes ☐ No How often? _____

Are you concerned with your weight? ☐ Yes ☐ No

Current Medical Conditions/Diagnosis	Date Diagnosed and Treatment

Medications/Supplements

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them.

Medications	Reason for taking	Date began	Dose and frequency	Helps? Yes or No

Supplements	Reason for taking	Date began	Dose and frequency	Helps? Yes or No

Family History

Please describe your family's health, including age or age at death, and major illness history (diabetes, heart disease, osteoporosis, endometriosis, cancer, allergies, mental illness, etc)

Family Member	Living?/ Age	Major illness or chronic conditions
Mother		
Father		
Sisters/Brothers		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

WOMEN ONLY

Are you sexually active? □ Yes □ No If yes, partner(s) is/are: □ Male □ Female

Do you or your partner use contraception? □ Yes □ No If so, what type(s)? _____

Are you pregnant? □ Yes □ No □ Not sure Number of children _____

Are you currently experiencing any gynecological symptoms or problems? □ Yes □ No

Any problems related to sexual function? □ Yes □ No

Do you have any history of sexually transmitted disease? □ Yes □ No

Do you have any history of cervical, ovarian or breast cancer? □ Yes □ No

Do you perform regular breast exams? □ Yes □ No

How old were you at onset of first menses? _____

If you are of menstruating age: Date of last period: _____

Periods generally last ____ days and occur every _____ days

Bleeding is □ heavy □ moderate □ light

List any PMS symptoms: _____

_____

If you are peri-menopausal or menopausal:

Are you taking hormone replacement therapy? □ Yes □ No

List any concerns: _____

Number of pregnancies and age at each: _____

Number of live births and your age at each: _____

Are you currently trying to conceive? □ Yes □ No

Please proceed to WOMEN'S symptoms checklist

MEN ONLY

Are you sexually active? □ Yes □ No If yes, partner(s) is/are: □ Male □ Female

Do you or your partner perform safe sex practices? □ Yes □ No

Do you ever experience any problems related to sexual function or libido? □ Yes □ No

Do you have any history of sexually transmitted disease? □ Yes □ No

Have you ever had a diagnosis of prostate enlargement or cancer? □ Yes □ No

Do you ever experience trouble with urination (frequency, hesitancy, pain, dribbling?) □ Yes □ No

Please proceed to MEN'S symptoms checklist

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WOMEN'S SYMPTOMS CHECKLIST:

Please circle the number that best describes how you have been feeling in most recent history (3-4 weeks)
0= None, symptoms not present
1= Mild, present but not bothersome or distressing
2= Moderate, distressing but not interfering with daily life
3= Severe, very distressing, interferes with daily life and relationships

Symptom	Severity				Comments
Hot flashes or flushing	0	1	2	3	
Night sweats	0	1	2	3	
Foggy thinking	0	1	2	3	
Bone loss	0	1	2	3	
Depression	0	1	2	3	
Vaginal dryness	0	1	2	3	
Memory lapses	0	1	2	3	
Incontinence	0	1	2	3	
Tearfulness	0	1	2	3	
Sleep disturbances/insomnia	0	1	2	3	
Heart palpitations	0	1	2	3	
Headaches	0	1	2	3	
Infertility	0	1	2	3	
Mood swings	0	1	2	3	
Breast tenderness	0	1	2	3	
Water retention/bloating	0	1	2	3	
Anxiousness/nervousness	0	1	2	3	
Irritability	0	1	2	3	
Fibrocystic breasts	0	1	2	3	
Uterine fibroids	0	1	2	3	
Weight gain (hips and thighs)	0	1	2	3	
Heavy menstrual cycles	0	1	2	3	
Breast cancer	0	1	2	3	
Sugar cravings (bread, pasta, chocolate)	0	1	2	3	
Low libido (sex drive)	0	1	2	3	
Menstrual flow changes	0	1	2	3	
Cold body temperature	0	1	2	3	
Increased facial and body hair	0	1	2	3	
Loss of scalp hair	0	1	2	3	
Acne	0	1	2	3	

Oily skin	0	1	2	3	
Decreased muscle mass	0	1	2	3	
Thinning skin	0	1	2	3	
Fibromyalgia	0	1	2	3	

Exhaustion/"tired but wired"	0	1	2	3	
Short-term stress	0	1	2	3	
Long-term stress	0	1	2	3	
Stress at home	0	1	2	3	
Stress in the workplace	0	1	2	3	
Recurrent infections	0	1	2	3	
Arthritis	0	1	2	3	
Allergies	0	1	2	3	
Need for caffeine	0	1	2	3	
Salt cravings	0	1	2	3	
Feeling cold	0	1	2	3	
Weight gain (abdominal area)	0	1	2	3	
Chemical sensitivities	0	1	2	3	

Thinning eyebrows	0	1	2	3	
Fingernail blemishes	0	1	2	3	
Hoarse voice	0	1	2	3	
Dry skin	0	1	2	3	
Muscle cramping	0	1	2	3	
Memory loss	0	1	2	3	
Goiter	0	1	2	3	
Anxiety	0	1	2	3	
Weight loss	0	1	2	3	
Eye changes	0	1	2	3	

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MEN'S SYMPTOMS CHECKLIST

Please circle the number that best describes how you have been feeling in most recent history (3-4 weeks)
0= None, symptoms not present
1= Mild, present but not bothersome or distressing
2= Moderate, distressing but not interfering with daily life
3= Severe, very distressing, interferes with daily life and relationships

Decrease libido	0	1	2	3	
Decreased number of spontaneous morning erections	0	1	2	3	
Decreased fullness of erections	0	1	2	3	
Spells of mental fatigue	0	1	2	3	
Inability to concentrate	0	1	2	3	
Episodes of depressions	0	1	2	3	
Muscle soreness	0	1	2	3	
Decreased physical stamina	0	1	2	3	
Unexplained weight gain	0	1	2	3	
Increase in fat distribution around chest and hips	0	1	2	3	
Sweating attacks	0	1	2	3	
More emotional than in the past	0	1	2	3	
Leg twitching at night	0	1	2	3	
Afternoon fatigue	0	1	2	3	
Insomnia or Cannot stay asleep	0	1	2	3	
Headaches	0	1	2	3	
Thinning of eyebrows	0	1	2	3	
Mental sluggishness	0	1	2	3	
Cravings for salt or sugar	0	1	2	3	

Informed Consent

- Hormone balance, nutrition and exercise are intended to promote general health and wellness and are not intended to replace physician care or medical intervention. All assessments, suggestions and consultations on hormones, nutrition, supplements, diet and exercise are based on your input and are not intended to diagnose, treat, or cure any disease or ailment.
- You accept all responsibility for reviewing recommendations for hormone balancing, diet, nutrition, lifestyle or exercise suggestions with a licensed medical professional before following said suggestions.
- Any activity or program may have inherent risks which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself. You agree to inquire about any activities with which you are not familiar, and provide any information which may limit your participation in suggested activities.
- Results and changes in your general health and wellness may vary depending on medical conditions, medications and accuracy in following suggested guidelines.
- As your general health and wellness may change with modification in hormone therapy, diet, nutrition and lifestyle, physician prescribed medications may require modification. It is your responsibility to discuss this with your physician. Never reduce or eliminate physician prescribed medications without the direction of your physician or medical care provider.
- Your personal health information will remain confidential and will not be shared without your consent/
- You give permission for the information provided on this form and discussed in your health assessment consultation to be shared with the primary care physician you have listed on this form, at the discretion of the health and wellness consultant and in the interest of your general health and wellness.
- Sujata B Patel, RPH and Wellness With Sujata., LTD reserve the right to refuse services to any individual.

By signing below, you agree to the above terms and conditions for participation in a health assessment consultation with Sujata B Patel RPH and/or Wellness With Sujata, LTD.

Print Name: _____

Signature: _____ Date: _____