INNOVATIVE
TRANSFORMATIONS

WELCOME!

CONGRATULATIONS!

You just made an extraordinary commitment to your health and wellness. Over the next several months we will work together to create the goals you set into existence for yourself and your life.

We will have two (2) sessions, per month accordingly to the package(s) you have selected. Please refer to the package that you have selected for more specific details.

During our sessions we will determine what goals you want to achieve and formulate attainable action plans. I will support you by providing guidance, encouragement, and holding you accountable to your word and commitment. Since most of this program occurs outside of our sessions, namely your everyday life, the results are up to you.

Please read and sign the following agreement:

I AM COMMITTED TO MY OWN PERSONAL HEALTH AND WELLNESS.

With this commitment I give my word to:

- Be coachable
- Be open to new foods, concepts, and exercises
- Fulfill on the commitments I make
- Eat nourishing foods according to the guidance of my Health Coach
- Exercise according to the guidance of my Health Coach
- Finding a healthy balance between work and play
- Give gratitude in the relationships in my life
- Develop a listening to my body's wants and needs
- Powerfully deal with the stressors in my life
- Begin and end our sessions on time

List any other additional comments:

_____

_____

_____

____

_____
Print Name

_____

_____
Signature

Date

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To help us both clarify what health goals or concerns you want to address during your program, please take a few moments to fill in the following and bring it to your first session.

Please write three goals for each time period.

ONE MONTH

1. _____
2. _____
3. _____

THREE MONTHS

1. _____
2. _____
3. _____

SIX MONTHS

1. _____
2. _____
3. _____

_____ _____

Print Name Date

_____

Signature

CONFIDENTIAL HEALTH HISTORY/INTAKE FORM
Please type, write or print clearly.

Name: _____

AGE:	**HEIGHT:**		**WEIGHT:**	

Current Weight:		**Weight Six Months Ago:**		**Weight One Year Ago:**	

Would you like your weight to be different? Circle YES or NO

If so, tell me why? _____

_____

_____

Relationship Status:		**Children?**	

Occupation:		**Hours Per Week:**	

Please list your main health concerns:	
Any serious illness, hospitalization, injuries, and surgeries, either now or in your past?	
How is the health of your mother? If deceased, relay illnesses.	
How is the health of your father? If deceased, relay illnesses.	
Other current major life concerns?	

What is your ancestry?		**Your blood type:**	

CONFIDENTIAL HEALTH HISTORY/INTAKE FORM

Please type, write or print clearly.

Do you sleep well?		**How many hours?**		**Do you wake up at night?**	
If not, tell me why:					

Any ongoing sources of inflammation (e.g. eczema or other skin irritation, chronic postnasal drip, congestion, headaches, achy muscles/joints, swelling, pain, stiffness)?	
When was the last time you felt vibrant and well?	
If you could wave a magic wand and change 2 things about your life right now, what exactly would they be?	

THIS SECTION FOR WOMEN ONLY					
Is your menstrual cycle regular?		**How many days is your flow?**		**How frequent?**	
Painful or symptomatic?			**Please explain:**		
Birth control history:					
Vaginal infections, reproductive concerns?					

Do you struggle with Constipation, Diarrhea, Gas, Distension, Belching, or Bloating? List them.		**Explain in detail:**	

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CONFIDENTIAL HEALTH HISTORY/INTAKE FORM
Please type, write or print clearly.

Please list ALL supplements or medications you take (prescription or over the counter) and frequency?
Have you ever taken antibiotics more than a short course or two as a child? If so, when/how often? For what? For how long?
Any remarkable exposure to toxins (e.g. current or childhood home, nearby industrial community, job, hobbies, travel, pesticides, heavy metals)?
What is the general status of your dental health/care?
Any troubling dental work or history of dental/oral infections? Dentures? Root canals?
How many silver/mercury fillings do you have? **Other major dental work/issues beyond basic cleanings?**
On a scale of 1 to 10 (1= lowest), how would you rate your general energy level?
To what do you attribute this energy level?
Any healers, helpers, pets or therapies with which you are involved? Please list:
What are your primary hobbies?
What role do sports and exercise play in your life?
What do you do to relax? How often?

CONFIDENTIAL HEALTH HISTORY/INTAKE FORM
Please type, write or print clearly.

What was your general health and well-being as a child?

What foods did you eat often as a child?

Breakfast		Lunch		Dinner		Snacks		Liquids

What's your food like these days?

Breakfast		Lunch		Dinner		Snacks		Liquids

Do you have any known food allergies or sensitivities?
If so, please list them.

What percentage of your food is home cooked?		What percentage is not?	

The percentage that is not home cooked, where do you get it from?

If you have a general philosophy, mindset or approach you use when choosing foods, please describe it briefly.

Do you crave sugar, carbs, alcohol, coffee, cigarettes, other foods, or have any addictions?

Anything else you would like share at this time?

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Confidential Symptom Questionnaire
Please write or print clearly

Name: _____

Please use this scale to rate the frequency and severity of symptoms you have experiences <u>over the past two years.</u>
If multiple choices are given, please specify what applies in the comment column.

- **Leave the score blank if you Never have the symptom.**
- **Use a 1 if you Occasionally have it and the effect is Mild.**
- **Use a 2 if you Occasionally have it and the effect is Severe.**
- **Use a 3 if you Frequently or Consistently have it and the effect is Mild.**
- **Use a 4 if you Frequently or Consistently have it and the effect Severe.**

Category	Symptom	Score	Comments, if applicable
HEAD	Headache		
	Faintness		
	Dizziness		
	Insomnia		
NOSE	Stuffy nose		
	Sinus problems		
	Hay fever		
	Sneezing attacks		
	Excessive mucus formation		
MOUTH	Chronic coughing		
	Gagging or frequent need to clear throat		
	Sore throat, hoarseness, or loss of voice		
	Swollen or discolored tongue, gums, or lips		
	Chronic tooth or gum pain or jaw pain. Which?		
	Canker sores		
SKIN	Acne		
	Hives or another allergic breakout		
	Rash or persistently dry skin		
	Hair loss		
	Flushing or hot flashes		
	Frequently feel cold		
	Excessive sweating		
	Part of body frequently feeling numb.		
HEART	Irregular or skipped heartbeat		
	Rapid or pounding heartbeat		
	Chest pain		

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Confidential Symptom Questionnaire
Please write or print clearly

Category	Symptom	Sore	Comments, if applicable
LUNGS	Chest Congestion		
	Asthma, bronchitis		
	Shortness of breath		
	Difficulty breathing		
DISGESTION	Nausea or vomiting		
	Diarrhea		
	Constipation		
	Bloated feeling		
	Belching, burping		
	Passing gas, flatulence		
	Heartburn		
	Intestinal or Stomach pain. Which?		
	Other pain in GI tract? Where?		
JOINT AND MUSCLES	Pain or aches in joints		
	Arthritis		
	Stiffness or limitation of movement		
	Pain or aches in muscles		
	Tremor or restless leg		
	Feeling of weakness or tiredness		