Lifetime Wellness Center

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# JSC Integrative Health Plan Profile:

Please complete this from and bring the completed form to your initial consultation.
(Please print clearly)

Name: _____ Date: _____

Date of Birth (M/D/Y): _____ Gender: _____

Address: _____ Apt./Unit: _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

Phone: _____ May we leave a message regarding your visit? Y / N

Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Widowed # of children _____

Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

List other health care providers you are seeing:

Name: _____ Name: _____ Name: _____

Specialty: _____ Specialty: _____ Specialty: _____

Phone: _____ Phone: _____ Phone: _____

Please summarize any recommendations/programs/testing you are currently experiencing with any of the above providers:

_____

_____

_____

_____

Have you ever consulted any of the following? (circle all that apply):

* Naturopathic Doctor * Acupuncturist * Homeopath * Nutritionist * Councilor * Chiropractor
* Massage Therapist * Reiki Practitioner * Psychic/Medium * Other_____

## Medical History:

How would you describe your general state of physical health? Excellent Good Fair Poor

How would you describe your general state of emotional health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, hospitalizations and approximate dates they occurred:

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Do you have any allergies (medicines, environmental, etc.)?

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Please list all **current** medications & natural products (prescription, over-the-counter, vitamins):

_____

_____

_____

_____

Please list all **past** medications & natural products (prescription, over-the-counter, vitamins):

_____

_____

_____

_____

**Please circle Yes (Y), No (N), or Past (P) regarding use of the following:**

* Aspirin, Tylenol, Advil or other pain relievers Y N P * Laxatives Y N P * Antacids Y N P
* Birth Control Y N P * Antibiotics Y N P * Approximate number of prescriptions Y N P

Alcohol Y N P - How much per day or week_____
Tobacco Y N P - Type and amount per day _____
Caffeine Y N P - Type and amount per day_____
Recreational Drugs Y N P - Type and amount per day_____

Do you get regular screenings from your medical doctor? (Blood, Mammogram, etc.) Y / N
Describe your results:

_____

_____

_____

_____

# Personal and Family History:

Please place an **X** in the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: **Self** is related to you. Father (**F**), Mother (**M**), Sibling (**S**) Grandparent (**G**) Your Child (**C**). Please write **Past** if the condition is resolved and the approximate date that occurred for you, or **Current** if it on-going and current for you at this time.

| | **Yes (X)** | **Relation Please circle** | **Dates Resolved** | | **Yes (X)** | **Relation Please circle** | **Dates Resolved** |
|---|---|---|---|---|---|---|---|
| Abuse/phys/mental/ sexual | | Self F M S G C | | Grief/Loss | | Self F M S G C | |
| Alcoholism/ Addiction | | Self F M S G C | | High Blood Pressure | | Self F M S G C | |
| Allergies | | Self F M S G C | | Heart Disease | | Self F M S G C | |
| Anemia | | Self F M S G C | | Hepatitis | | Self F M S G C | |
| Arthritis | | Self F M S G C | | Headaches | | Self F M S G C | |
| Asthma | | Self F M S G C | | Kidney Disease | | Self F M S G C | |
| Cancer | | Self F M S G C | | Lyme Disease | | Self F M S G C | |
| Diabetes | | Self F M S G C | | Osteoporosis | | Self F M S G C | |
| Depression/Other Mental Diagnosis | | Self F M S G C | | Self-harm/Suicide | | Self F M S G C | |
| Eating Disorder | | Self F M S G C | | Stroke | | Self F M S G C | |
| Eczema | | Self F M S G C | | Tuberculosis | | Self F M S G C | |
| Epilepsy | | Self F M S G C | | Others: | | Self F M S G C | |

## Current Lifestyle Status:

Do you have any food allergies or intolerances? Please list:

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Do you feel you have a healthy relationship with food? Y / N
If no, please describe?

_____

_____

Do you engage in some type of regular activity? Y / N

What type of activity do you like to do? How long and how often?

_____

_____

Do you enjoy being active? How do you feel after activity?

Would you describe yourself as a confident person? Y / N

Do you feel you have a healthy relationship with your body? Y / N

Is intimacy important to you? Y / N

Are you satisfied with the relationships in your life? Y / N

If no, please explain:

Are you exposed to tobacco smoke at work or at home? Y / N

Are you frequently exposed to animals at work or at home? Y / N

Have you been exposed to heavy metals, pesticides or other toxic materials in your home or at work? Please describe:

How stressful is your work or other aspects of your life? How well do you handle these stresses?

What is your overall satisfaction with your quality of life? Low Satisfied Very Satisfied

How would you like to see it improve? Is there anything that you feel is important that has not been covered?

| Please list your most important concerns & goals in their order of importance. |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

Please indicate painful or distressed areas: