

ENGAGE
Twelness **CLIENT ASSESSMENT FORM**

First Name..... Surname.....Blood Type.....

Date of birth.....Today's date.....

Address.....

.....Postal Code.....

Tel. home..... work.....cell.....

Occupation..... E-mail.....

Emergency Contact/ Parents Phone #.....

Please Circle:

I am *Single/Married/Divorced/Separated/Widowed/With partner*
I live with *Spouse/Partner/Friend/Children/Parents/ On my own*
I am currently *Employed/Unemployed/Self Employed/Student*

My current health concern(s) is/are:

1.....

2.....

3.....

4.....

Current medically confirmed Diagnosis.....

.....

PREGNANCY/BIRTH

Did **your mother's pregnancy** progress to full term in a healthy manner; if not, please explain: YES NO

.....

Was it followed by a normal vaginal delivery, and if not, please explain: YES NO

.....

Have you been breastfed? YES, for how long?d/m/y NO

MEDICAL HISTORY

Please list all **diseases, physical traumas and operations** that you have had and your **age** when they occurred: **i.e. tonsillectomy age 4 concussion age 12 Physical trauma age of event**

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Please use back of page if more space is required.

Please check for the past or current **tendency** to experience the following dysfunction repetitively:

- | | | | |
|------------------------------|-----------------------------|---|---|
| Skin irritation | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Muscles and joint pain/aches | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Excessive sweating | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Indigestion | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Bloating/flatulence | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Constipation | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Diarrhoea | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Appetite oscillations | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Breathing difficulties | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Palpitations | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Frequent urination | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Tiredness | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Emotional difficulties | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Insomnia | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |
| Frequent infections | <input type="checkbox"/> NO | <input type="checkbox"/> YES, in the past | <input type="checkbox"/> YES, currently |

Others.....

.....

Females only

Age at onset menstruation?.....

Age at onset menopause?.....

Have you taken **oral contraceptive pills**? NO YES, how long?.....

Have you taken **Hormone Replacement Therapy (HRT)**? NO YES, how long?.....

Females Only: Have you ever **experienced** any of the following? (Please check)

Irregular periods <input type="checkbox"/>	Uterine fibroids <input type="checkbox"/>	Extrauterine pregnancy <input type="checkbox"/>
Absence of period <input type="checkbox"/>	Normal birth <input type="checkbox"/>	Eclampsia <input type="checkbox"/>
Metrorrhagia (haemorrhage) <input type="checkbox"/>	Miscarriage <input type="checkbox"/>	Diabetes during pregnancy <input type="checkbox"/>
Infection in reproductive organs <input type="checkbox"/>	Abortion <input type="checkbox"/>	Placenta praevia <input type="checkbox"/>
Ovarian cyst <input type="checkbox"/>	Still birth <input type="checkbox"/>	Infertility <input type="checkbox"/>
Endometriosis <input type="checkbox"/>	Premature birth <input type="checkbox"/>	Cervical dysplasia <input type="checkbox"/>

Family History

Please fill in the relevant medical details of your family members.

Diseases:

- Malignant Diseases YES NO
- Congenital Disease YES NO
- High Blood Pressure YES NO
- Heart Disease YES NO
- Blood Disease YES NO
- Lung Disease YES NO
- Stomach Disease YES NO
- Bowel Disease YES NO
- Liver/Gall Bladder Disease YES NO
- Kidney Disease YES NO
- Arthritis YES NO
- Bone Disease YES NO
- Diabetes YES NO
- Thyroid Problem YES NO
- Stroke YES NO
- Multiple Sclerosis YES NO
- Epilepsy YES NO
- Psychiatric Disease (depression...) YES NO

Family Member:

-
-
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-
-

Other, Please Specify:

.....

Please give **name, dosage and frequency** of any current **medication** and when you started taking it:

Current medication:

Started:

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

If you are currently receiving/practicing any **alternative therapy (s)**, please specify:

.....
.....
.....

List any **remedies, supplements, vitamins or herbs** you are taking and when you started taking it:

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

Do you experience fatigue? Please circle: upon rising/ all day/ afternoon crash/ after supper crash

Please describe your sleep pattern:

.....

DENTAL HISTORY

Do you have the following:

- | | | | |
|------------------------------|------------------------------|-----------------------------|-------------------------|
| Bleeding gums? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Amalgams (silver fillings)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If yes, how many? |
| Root canal procedure done? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | If yes, how many? |
| Parodontosis (receding gums) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |

If any other dental work has been done, please list:

.....	age	.....
.....	age	.....
.....	age	.....

DIET

Do you eat 3 meals per day? YES NO, please explain

Please list what you ate **yesterday**: / List what you ate **two days ago**:

Breakfast...../.....

Snack...../.....

Lunch...../.....

Snack...../.....

Dinner...../.....

Snack...../.....

How much **water** do you drink daily? cups

Do you drink: COFFEE..... cups TEA, black.....cups herbal.....cups greencups

ALCOHOL.....cups Juice cups Milk cups type.....

ALLERGIES/SENSITIVITIES/DEFICIENCIES/TOXICITIES

Do you have any **medically confirmed** allergy? NO YES, please list

.....
.....

Does **any** other substance trigger the experience of allergy- like symptoms? NO YES, please list

.....

Do you have any food cravings? NO YES, please list

.....

Have you been exposed to any of the following:

Agricultural chemicals? YES NO

Industrial/workplace chemicals? YES NO

Cigarette smoking? YES NO How much?..... How long?.....

Alcohol use? YES NO How much?..... How long?.....

Recreational drugs? YES NO How much?..... How long?.....

Other, please explain

SELF-ASSESSMENT

Please list chronologically the events in your life that have had a major psychological impact on you and give your age when they occurred. i.e. dog died age 10, moved towns age 16, boyfriend cheated on me age 25

.....
.....
.....
.....
.....

My major positive and negative **characteristics** are (+)..... (-).....

My repetitive **dream** is

My deepest **fear** is.....

My **hobbies** include.....

Other **relevant information** that you feel like conveying at this point:

.....
.....

Stress Management

Please underline the most frequent trigger of your stress:

Relationships with/Money/Job Security/ Other(s)-Please Specify

.....

Please underline the **physical signs** of your stress and **circle** the most frequent one.

*Tiredness / Headaches / Neckache / Backache / Chest pains / Palpitations / Digestive problems /
Frequent urination / Loss of Libido / Period problems / Frequent infections / Sleep problems / Weight
gain or loss / Excessive sweating / Other(s)- please specify*

.....

Please underline the **psychological signs** of your stress and **circle** the most frequent one.

*Moodiness / Apathy / Depression / Anxiety / Frustration / Indecision / Boredom / Guilt / Poor
concentration / Aggressiveness / Clumsiness / Other(s)- please specify*

.....

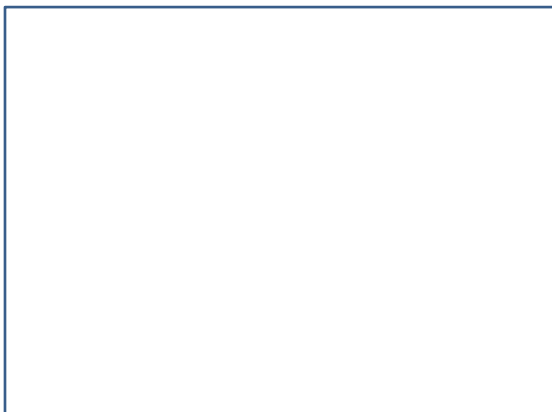
Please underline the **behavioural signs** of your stress and **circle** the most frequent one.

*Being accident- prone / Addictions (alcohol, drugs, smoking, tea, coffee) / Withdrawal / Conflict making /
Absenteeism / Other(s)- please specify*

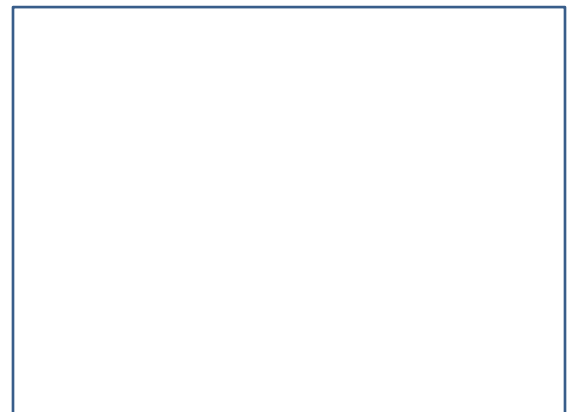
.....

Please draw **two pictures** that represent:

1. My Health Condition



2. My Ideal Life



The name and contact telephone number of **your GP**.....

The name and contact telephone number of **your dentist**.....

How did you hear about us?.....

PAYMENT METHOD

Please note that **settlement of all accounts remains the client’s responsibility (or the parent/ guardian of a child under 18 years of age)**, and not any third party. The consultation fee of **\$140.00 - \$250.00** (depending upon appointment type), **is payable immediately following the appointment**. A **full fee** will be charged for any cancelled or broken appointment **without 24 hours’ notice**. **I understand that supplementation, Nanopharmaceuticals and therapeutic treatments are not included in the consultation fee.**

I confirm that I accept the responsibility for all treatments in the Engage Wellness Centre including all charges for any services and supplementation provided.

Signature of Patient/Parent or Guardian: Date:.....

CLIENT COMMITMENT AGREEMENT

Iagree that my progress and wellness goals are dependent upon me taking responsibility to follow the recommended protocol as set out by the Wellness Practitioner. I understand that I may be asked to modify my regimen including my diet, exercise, and sleep patterns, and I agree that I am willing to give a valiant effort to make the necessary modifications to achieve my health goals, asking questions when I need clarification. I understand that reversal of disease is a process and that it takes time and determination to achieve optimal wellness. I agree to keep my regularly scheduled appointments in order to optimize my desired state of health, wellbeing, and success. I am committed to taking an active role in my wellness goals.

Signature of Patient/ Parent or Guardian: Date:

*Please note, in the interest of others, that The Engage Wellness Centre is **a Mobile Phone Free Zone**. You are kindly requested to step outside the building if you wish to use your mobile phone.*

WELCOME TO THE ENGAGE WELLNESS CENTRE

We are happy to be working with you to achieve
your desired health and wellness goals.

613-448-4382

www.engagewellness.ca