CONFIDENTIAL- FOR MEDICAL PURPOSES ONLY

ENGAGE Twellness

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***

…… …… …… ……

…… …… …… ……

…… …… …… ……

…… …… …… ……

…… …… …… ……

…… …… …… ……

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	□NO	□YES, in the past	□YES, currently
Muscles and joint pain/aches	□NO	□YES, in the past	□YES, currently
Excessive sweating	□NO	□YES, in the past	□YES, currently
Indigestion	□NO	□YES, in the past	□YES, currently
Bloating/flatulence	□NO	□YES, in the past	□YES, currently
Constipation	□NO	□YES, in the past	□YES, currently
Diarrhoea	□NO	□YES, in the past	□YES, currently
Appetite oscillations	□NO	□YES, in the past	□YES, currently
Breathing difficulties	□NO	□YES, in the past	□YES, currently
Palpitations	□NO	□YES, in the past	□YES, currently
Frequent urination	□NO	□YES, in the past	□YES, currently
Tiredness	□NO	□YES, in the past	□YES, currently
Emotional difficulties	□NO	□YES, in the past	□YES, currently
Insomnia	□NO	□YES, in the past	□YES, currently
Frequent infections	□NO	□YES, in the past	□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 □	Uterine fibroids □	Extrauterine pregnancy □
Absence of period □	Normal birth □	Eclampsia □
Metrorrhagia (haemorrhage) □	Miscarriage □	Diabetes during pregnancy □
Infection in reproductive organs □	Abortion □	Placenta praevia □
Ovarian cyst □	Still birth □	Infertility □
Endometriosis □	Premature birth □	Cervical dysplasia □

Family History

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

Diseases:			**Family Member:**
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	……

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?	□YES	□NO	
Amalgams (silver fillings)?	□YES	□NO	If yes, how many? ……
Root canal procedure done?	□YES	□NO	If yes, how many? ……
Paradentosis (receding gums)	□YES	□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 green ……..cups

□ ALCOHOL……..cups □ Juice …… cups □ Milk …… cups type……..

ALLERGIES/SENSITIVITIES/DEFICIENCES/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

I ……agree 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