Good Works Wellness Research, LLC

Pamela Reilly, Naturopath, CNHP, CNC, CPH
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http://www.goodworkswellness.com

Client Information and Wellness History

Client Name: _____ Date: _____

Parent or Guardian Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Date of Birth: _____ Gender: M F

Height: _____ Current Weight: _____ Desired Weight: _____

Primary Physician's Name: _____ Phone Number: _____

Address: _____

My top three health concerns are:

_____ Treatment(s) Used: _____

_____ Treatment(s) Used: _____

_____ Treatment(s) Used: _____

Please list all prescription medications you take and the physician(s) who prescribed them:

Medication	Dosage/Frequency	Prescribing Doctor

(Additional prescription medications may be written on the back of this page if needed.)

Known allergies to medication, supplements or herbs? _____

Please list all dietary supplements you take and why you take them:

Supplement	Dosage/Frequency	Reason(s) for Taking

(Additional supplements may be written on the back of this page if needed.)

Please describe normal meals for you:

Breakfast	
Lunch	
Dinner	
Snacks	

When was the last time you had bloodwork done? _____ Did you bring copies of it with you today? _____

Privacy Policy: *Your identity and wellness history will be kept confidential and will not be revealed to anyone or to any organization without your permission.*

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Please list any surgeries or hospitalizations, including dates: _____

_____

Do you rely on a spiritual resource for support and encouragement? Please describe. _____

_____

Are you in a relationship? _____ How many children to do you have? _____

What is your stress level?_____How do you deal with stress? _____

What is your occupation?_____

Please indicate:

_____ # Alcoholic beverages per week
_____ # Caffeinated beverages per day
_____ # Cigarettes per day
_____ # times Nonprescription drugs used per week
_____ # days of Exercise per week
_____ # servings of sugar per day

_____ # Minutes exercised when exercising
_____ # Servings fruits/vegetables per day
_____ # Minutes of prayer/meditation per day
_____ # Hours sleep per night
_____ # Glasses water consumed per day
_____ # times you eat each day

Please describe your bowel movements (frequency, color, consistency, etc.): _____

_____

Please describe any chronic pain you have, including the location(s), severity, frequency, etc.

_____

Please indicate if you have experienced any of the following in the past three years:

_____ Allergies - Food
_____ Allergies – Seasonal, Environmental, Animal
_____ Asthma or other breathing problems
_____ Breathing Problems
_____ Cancer – Year: Location:
_____ Constipation
_____ Blood sugar imbalances / Diabetes
_____ Diarrhea/loose stools
_____ Dizziness
_____ Edema/Water Retention
_____ Emotional issues (depression, anger, etc.)
_____ Endometriosis/Fibroid Cysts/etc.
_____ Fatigue: Mild Moderate Extreme
_____ Food cravings
_____ Frequent colds/flus
_____ Frequent Urination
_____ Frequent Use of Antibiotics
_____ Fungal Infections (nails, vagina, feet, etc.)
_____ Hair loss or thinning
_____ Headaches
_____ Heart or Circulation Problems

_____ Heartburn, Indigestion
_____ Heart Palpitations
_____ High or Low Blood Pressure
_____ High Cholesterol/Triglycerides
_____ Inability to Lose Weight
_____ Insomnia or sleep difficulties
_____ Joint pain unrelated to activity
_____ Kidney problems
_____ Lack of appetite
_____ Menstrual pain or irregularities; Infertility
_____ Muscular pain unrelated to activity
_____ Poor memory or "Brain Fog"
_____ Pregnancy
_____ Respiratory problems
_____ Sexual issues
_____ Shortness of breath
_____ Skin Issues (acne, eczema, psoriasis, etc.)
_____ Slow healing sores
_____ Thyroid Issues
_____ Unexplained weight gain or loss
_____ Vision Issues

Please use the back of this sheet to share anything else you feel I should be aware of.

Please note that all payments are due at time of service. Twenty-four hour notice is required to cancel an appointment. A$25 fee will be charged for all appointments canceled without 24-hour notice.

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Good Works Wellness Research, LLC Disclaimer

- I understand that Pamela L. Reilly is a Certified Natural Health Practitioner, Certified Nutrition Counselor and Certified Practicing Herbalist and is not a licensed physician or medical doctor (MD).

  _____ Initials

- I understand that Certified Natural Health Practitioners are trained specialists who use non-invasive, natural medicine such as vitamins, minerals, herbs, dietary changes, Bach Flower Remedies, etc., to create a healthy environment and eliminate imbalances in the body.

  _____ Initials

- I understand that my visit today and any recommendations made are based on the belief that the body has a natural ability to heal itself if given the appropriate internal and external environment.

  _____ Initials

- I understand that nothing said, done, typed, printed, reproduced or shared in any way by any representative of Good Works Wellness Research, LLC is intended to diagnose, treat, cure, alleviate, or prescribe for any medical condition or disease and is not intended to take the place of treatment by a licensed medical doctor (MD).

  _____ Initials

- I understand that I am solely responsible for my own healthcare and for the lifestyle decisions I make. I also attest that my sole reason for seeking counsel from Good Works Wellness Research, LLC is to receive nutritional advice for improving my health and wellness.

  _____ Initials

- I understand that any tests ordered or recommended on saliva, blood or urine are intended to identify nutritional deficiencies and are not intended to diagnose, treat or cure any disease.

  _____ Initials

- I understand that I should continue seeing my medical doctor(s) and should not stop taking or alter the dose of any prescription medication I am taking without first consulting with the prescribing physician.

  _____ Initials

- I understand that I may be referred to another natural health provider or physician for additional care if deemed necessary.

  _____ Initials

- I understand that signs of physical, mental, supplemental deficiency or dietary stressors may be identified today and information about traditional uses of supplementation to attempt to create a healthy balance in the body may be discussed. This is not intended to be interpreted as diagnosis, treatment, or a plan of cure for any medical condition or as a substitute for treatment by a licensed medical doctor (MD).

  _____ Initials

- I understand that Iridology readings, Muscle Response Tests, or any other physical assessments performed are solely for the purpose of identifying nutritional deficiencies and are not intended to diagnose, treat or cure any disease.

  _____ Initials

- I am not on this visit, any subsequent visit, or in any communication or correspondence with a representative of Good Works Wellness Research, LLC acting as an agent for a federal, state, county, local agency or news media on a mission of entrapment or investigation.

  _____ Initials

- I understand it is possible for any substance to create a negative response in persons who are sensitive to it, that sensitivity cannot always be predetermined, and that I should stop taking any recommended supplements and contact Pamela immediately if I experience any negative reaction.

  _____ Initials

- I agree to not hold Pamela Reilly or any other agent of Good Works Wellness, LLC liable for any negative effect experienced by any supplement, lifestyle or dietary change recommended.

  _____ Initials

I have read the above information and discussed it with a representative of Good Works Wellness Research, LLC and agree with all statements completely.

Signature: _____ Date: _____

Please Print Name Here: _____

Email: _____

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