True Health Wellness Studio
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Personal Health History & Lifestyle Questionnaire: Client Intake, Acknowledgement & Consent Form

Strictly Private and Confidential

Personal Information Date:_____

Full Name: _____

Preferred Name_____

Address_____

Email_____ Phone (mob/landline)_____

Gender DOB Age Occupation

Emergency Contact: Name_____ Phone #_____

Referred By: Name_____

Education: _____

Living Situation (marital statues, pets, alone: home as respite or stressful).

_____

_____

Children: Y___ (if Yes, how many)? #_____ N___

What brings you in today? _____
_____

How did you hear about my services? _____

Current overall Health Condition:

____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

What do you attribute your current situation, symptoms or health issue?
_____
_____
_____

Relevant Health History

Primary physician or health care professional:
Name: _____
Date of last physical exam: _____

Last appointment and reason: _____
_____

Does your physician know that you are participation in an exercise/ fitness program? Y_____ N _____

Other health care professionals you see:_____

Current or chronic medical conditions, diagnosis, or treatment with dates: _____
_____
_____
_____
_____
_____
_____
_____
_____

Mental health issues or diagnosis: _____
_____
_____
_____

Hospitalizations/ surgeries (conditions/date/year): _____
_____
_____
_____
_____

Significant physical or emotional traumas (conditions/date/year): _____
_____
_____
_____

Current medication/prescription or over-the counter medications:
_____
_____
_____
_____
_____
_____

Supplements Used:

____ Vitamins ___ Minerals ___ Herbs ___ Homeopathic
____ Flower Essences ___Other
Please list supplements and reason for usage below.
_____
_____
_____
_____
_____
_____

Sleep quality and sleep aid usage: _____
_____
_____
_____

Lifestyle: Exercise and Physical activity

For the following questions, pleas mark, which best applies to you.

Are you currently involved in a regular fitness program? Y_____ N_____

Are you involved in physical activities of daily living? (Walking, gardening, etc.)? Y_____ N_____

If Yes, what types and how often? _____
_____
_____
_____

Are you involved in cardiovascular exercise or a group fitness program? Y_____ N_____

If Yes, what types and how often? _____
_____
_____
_____

Are you involved in a strength training and or weight lifting program? Y_____ N _____

If Yes, what types and how often? _____
_____
_____
_____

Do you consider yourself?

A. Sedentary	
B. Lightly active (sporadic workouts, lawn work, little aerobic work)	
C. Moderately active (work out 1-2 days/ week for at least 15-30 minutes.	
D. Highly active (work out 3 or more days/ week for at least 30-45. minutes	

Do you believe that you are physically fit?

No		Less than average	
Above average		Outstanding	
Don't know			

Indicate the main reason you exercise or why you want to begin an exercise program.

It's good for my health.		Helps to relieve stress.	
My doctor told me to.		I'm trying to lose weight.	
It makes me feel good.		Other	

What activities would/ do you prefer in a regular exercise program?

Walking and or running		Racquetball or squash	
Swimming		Tennis	
Stationary cycling/ bike		Basketball	
Stretching		Yoga/ Pilates	
Rowing		Strength/resistance / weight training	
Group fitness classes		Elliptical	
Biking		Stairmaster/climber	
Not sure		Other	

Do you smoke? Y_____ N _____
If Yes, How much and how often? _____
_____

If you use to smoke, but quite? Why, how often and when did you quite smoking?

_____
_____
_____
_____
_____

What role does sports and exercise paly in our life? _____
_____
_____
_____
_____
_____

Please list any hobbies or activities: _____
_____
_____
_____
_____
_____

Eating Habits, Patterns and Fluid Intake

What food did you eat often as a child? List some of these foods.

_____
_____
_____
_____
_____
_____

What types of foods do you eat these days? List some of these foods.

_____
_____
_____
_____
_____
_____

Do you cook? Y_____ N _____

Daily water consumption amount ml/l (i.e. 1 cup, 500ml, 1 litre etc.).____
_____

Do you drink caffeinated drinks? Y_____ N_____

If Yes, which ones, how much and how often? _____
_____
_____
_____
_____

Do you drink pop/ soda? Y_____ N_____ Diet_____ Regular _____

List types of pop/ soda (i.e. Coke, Pepsi, Sprite, Root Beer, 7-up, Coke Zero etc.)_____
_____
_____
_____
_____

Do you crave sugar, salt, coffee, cigarettes, alcohol, or have any major addictions? Y_____ N _____

If yes, please explain and times of the day that you have these cravings.
_____
_____
_____
_____
_____
_____
_____

Nutrition/Food Diary- 3 Week Days and 1 Weekend Day

Day 1. Breakfast	Lunch	Dinner	Snack (am/pm)
Day 2. Breakfast	**Lunch**	**Dinner**	**Snack (am/pm)**
Day 3. Breakfast	**Lunch**	**Dinner**	**Snack (am/pm)**

Weekend Day			
Day 1. Breakfast	**Lunch**	**Dinner**	**Snack (am/pm)**

Informed Consent (Professional Disclosure & Release of Liability)
The purpose of this form is to present risks and benefits to the therapies I offer. Please initial the section below.

This is signed before therapy is rendered. Ask me if you have any questions or concerns at any time.

Supplements, Herbals/ Botanicals, Homeopathic

Initial: _____ Date:_____

These are products that can aid in healing by nutritional energetic and mechanical support. They can be effective for many conditions. Be sure to inform your practitioner about any medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, immune response and less commonly allergic reactions.
Please inform Angela Ford-Riemche of any changes in symptoms, and if there is a chance of pregnancy at anytime during your care.

Disclaimers:

The Client understands that the role of the Integrative Health, Wellness, and Energy Healing Practitioner is not to provide primary health. We do not provide health care, medical or services; or to diagnose, treat or cure any disease, condition of the human body. Please see your medical doctor for medical care specific to your needs. Rather, the energy healing practitioner is a mentor and guide who has been trained in holistic health coaching, nutrition, and energy healing to help clients reach their own health goals by helping clients devise and implement positive, sustainable lifestyle changes, by helping to clear energy blockages in the body. The Client understands that the practitioner is not acting in the capacity of a medical doctor, psychologist or other similar licensed or registered professional, and that any advice given by the practitioner is not meant to take the place of advice by these professionals. If the Client is under the care of a health care professional or currently uses prescription medications, the Client should discuss any dietary changes or potential dietary supplements use with his or her doctor, and should not discontinue any prescription medications without first consulting his or her doctor. The Client has chosen to work with the energy-healing practitioner and understands that the information received should not be seen as medical or nursing advice and is not meant to take the place of seeing medical doctors.

Personal Responsibility and Release of Health Care related claims:

The Client acknowledges that the Client takes full responsibility for the Client's life and wellbeing, as well as the lives and wellbeing of the Client's family and children (where applicable), and all decisions made during and after this program. The Client expressly assumes the risks of the Program, including the risks of trying new foods or supplements, and the risks inherent in making lifestyle changes. The Client releases the practitioner/coach from any and all liability, damages, causes of action, allegations, suits, sums of money, claims and demands whatsoever, in law or equity, which the Client ever had, now has or will have in the future against the practitioner/coach, arising from the Client's past or future participation in, or otherwise with respect to, the Program, unless arising from the gross negligence of the practitioner/coach.

Confidentiality & Privacy Policy:

The integrative health practitioner/ energy therapist will keep the Client's information private and will not share the Client's information to any third party. The information we collect about you is private and confidential. Your information is used, solely by your integrative health practitioner/energy-healing therapist at THW. In the interests of providing integrated healthcare, there may arise a circumstance where information is shared among healthcare professionals outside of THW, but only with your signed consent. Your information will not be given to any third party unless required by law.

We will communicate via email only when required for the following reasons. If you do NOT wish to receive emails, please place any in the box:
☐ Appointment requests, confirmations and reminders ☐ Receipts ☐

Clinic Events ☐ Monthly Newsletter

Payment Policy:

Payment is due at the time of your visit. We accept cash, cheque, debit, VISA and MasterCard. In consideration of people who may be on a waiting list for an appointment, we ask that you give us at least 24 hours notice of an appointment that will not be kept.

Acknowledgement:

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by True Health Wellness (THW), Angela Ford-Reimche M.Sc, Ph.D (cand), CET is to be used for educational purposes only. I also acknowledge that neither, TWH, Angela Ford-Reimche M.Sc, Ph.D (cand), CET claim to be medical doctors and will not prescribe for or diagnose any disease or condition. I also understand that THW, Angela Ford-Reimche, M.Sc, Ph.D (cand), CET does not bill insurance companies and that it is my responsibility to pay by, pay-pal, email money transfer, check or cash in full or at the time of service. I further understand that I must give 24 hours notice to cancel an appointment or I will be held financially responsible for the

appointment. The preceding answers are true and correct to the best of my knowledge. If I experience any changes in my health or current medications, I will immediately communicate this information to THW Angela Ford-Reimche M.Sc, Ph.D (cand), CET. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold True Health Wellness, Angela Ford-Reimche M.Sc, Ph.D (cand), CET liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive. I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the therapies initialled above. I release the provider from any and all claims of malpractice, non-disclosure, or lack of informed consent.

Client's Name (print) _____ Date: _____

Signature_____

Practitioner/ Coach Name _____ Date:_____

Signature_____