Holistic Wholeness Institute

Live Your Best Life!
732.813.1133
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HolisticWholenessInstitute.com

New Consultation Packet

Steps for your appointment:

1) *Please fill out all forms in their entirety within the next 24 hours. We will contact you if an appointment opens up sooner than your scheduled time so having these done ahead of time is important.*

2) If you have any recent labs (within 12 months), feel free to send them to us prior to your appointment. This is not required although welcomed. (Email our HIPAA compliant, encrypted email: info@holisticwholenessinstitute.com or fax it to us at 732-209-8437. Call us if you need help: 732-813-1133) If you have a partner, please ensure your **partner** or significant other is with you for your appointment. (There will be much information covered concerning your unique condition as well as the fundamentals of the program)

4) Please arrive **on time or 10 minutes early**. *Click on the zoom link in your email at least ten minutes prior to your appointment* so that you can call us ahead of time if you need help. Our wellness department can be reached at 732-813-1133

5) We require at least **24-hours notice (or 1 business day** if a weekend/holiday falls within 24 hours of your appointment) to change your appointment as we have a wait-list of individuals waiting to get in that we can help with proper notice. Note: *If these steps are not followed it may compromise the full value of your consultation and therefore, we will kindly reschedule your appointment.*

Wellness Programs

At Holistic Wholeness Institute we practice in a holistic manner, but believe in the science of appropriate testing to get to the root of the problem.. This type of practice is actually called "functional medicine".

We use testing, whether it is analysis of blood, saliva, urine, stool, hair and other means to give us objective evidence of your current state of health. We then can use these same tests to measure positive functional changes.

All of our treatment is directed towards the *cause* of dysfunction and not to simply cover up your symptoms with medication. By no means do we claim to treat specific diseases, nor offer any cure. No doctor or medication can actually cure the body. Healing is the responsibility of your own body's intelligence.

We offer solutions to help balance the body using specific and customized nutritional and nutraceutical protocols, allowing the body to do what it is programmed to do…*Heal Itself*.

Our team is not able to and does not accept every case. As many of you know and have seen firsthand, our schedule is extremely busy, therefore the number of practice members are strictly limited to ensure a high quality of care.

If you are currently on prescription medication, we ask you not to make any changes or go off of these medications without first consulting with your doctor that prescribed them. We are providing wellness consulting services and this should not be in lieu of medical advice.

It is the responsibility of your prescribing doctor to make these changes and work with us toward helping you become as drug-free as possible.

I have read this Wellness Program disclaimer and understand its content,

Signature:_____Date: _____ Print Name: _____

MEDICAL HISTORY

Full Name:_____ Nickname:_____Date: _____ DOB: _____

Complete Address:

Street _____Town_____State_____

Zip Code_____

Select Gender:

_____Female

_____Male

Best Number to Reach You: _____Cell: _____

Email_____Relationship Status: _____Occupation: _____

Employer: _____Physician Name: _____

Physician Phone#/Location: _____

Emergency Contact Name and Number: _____

How did you hear about us?_____

Primary Health Concerns:

_____

_____

_____

Of Your Main Complaints Above, List In Order of Importance (in your opinion)

1)_____2)_____

3)_____4)_____

Additional:_____

_____

Height: _____ Weight: _____Waist Size:_____

Usual Body Weight & how long ago?: _____

Past Medical History:

Have you been diagnosed with any of the following? Check all that apply.

___Anemia

___Hepatitis

___Asthma

___High Blood Pressure

___Blood clot/thrombosis/DVT

___High Cholesterol

___Chemical dependency/alcoholism/drug use

___Kidney Disease

___Circulatory Issues

___Multiple Sclerosis

___Cancer

___Parkinson's Disease

___Depression

___Anxiety

___ Rheumatoid Arthritis

___Eczema or Psoriasis/Other skin conditions

___Stroke/CVA/TIA Heart/Cardiac Issues

___Tuberculosis

___Pacemaker

___Epilepsy

___Thyroid Issues

___Diabetes

___Arthritis

___Other: _____

Please list any past surgeries and dates:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

For women: Are you currently pregnant? (Select one): ___YES ___ NO

How far along? (Select one) _____1st Trimester ____ 2nd Trimester ____3rd Trimester

Current Menstrual Status:

First Day of Last Menses: _____

_____Regular cycles

_____Hysterectomy

_____Irregular cycles

_____Ovaries Removed

_____No menstrual cycles in less than one year

_____Currently breastfeeding

_____Recently postpartum

_____No menstrual cycles greater than one year

Current Menstrual Phase:

_____Post- menopausal

_____Pre-menopausal

Hormone Medication used in the last 2 months (including steroids):

Name_____dosage_____form (tablet, injection, cream, etc)_____

Name_____dosage_____form (tablet, injection, cream, etc)_____

Name_____dosage_____form (tablet, injection, cream, etc)_____

Name_____dosage_____form (tablet, injection, cream, etc)_____

<u>Food & Nutrition History:</u>

Do you follow a specific diet?

_____

Please list any medications you are currently taking (over the counter and prescription):

_____

_____

Please list any any supplements and/or vitamins you are currently taking:

_____

How is your appetite?

_____

Please list any allergies (food, fragrance, latex, medications, etc.):

_____

Client History:

Have you ever smoked? ____YES ____ NO
If so, how many packs per day & for how long? _____

Is your sleep affected by what is bringing you in today? Describe your sleep pattern:

_____

Do you exercise? If so, how often? (Select one):

____NONE ____1-3X A WEEK ____3-5X A WEEK ____5-7X A WEEK

What type and for how long?_____

What activities are difficult due to your health issue(s)?

_____

_____

What activities or treatments help your health issue(s)?

_____

_____

How long have you suffered with these health issues? _____

Would you like improvement with any of the following?

__Digestion: Reflux, Gas, Constipation

__Sleep: Falling asleep or staying asleep

__Sense of Well Being

__Energy

Have you become discouraged or stressed about handling these health issues?

_____

When your health issues are at their worst, how does it make you feel emotionally? Physically?

_____

_____

How do your health issues interfere with the following areas in your life?

Work: _____
Family:_____
Hobbies: _____
Life: _____

Do you know how these health issues may have started?

_____

Are you here visiting us to:

____Resolve my immediate problem
____Lifestyle program for optimized living
Other: _____

How have you taken care of your health in the past?

____Medications ____Holistic
____Routine medical ____Vitamins
____Exercise ____Chiropractic
____Diet and Nutrition ____Other: _____

How did the previous methods work and/or NOT work for you?

_____
_____

What are you afraid this might be or will be affecting without change?

__Job __Kids __Marriage __Sleep
__Freedom __Future abilities __Finances __Time __Other_____

Are there any health conditions you are afraid this might turn into?

__Diminished future abilities __Surgery
__Stress __Arthritis __Weight gain __Cancer
__Heart disease __Diabetes __Depression __Other: _____

Where do you picture yourself being in the next 3-5 years if these health issues are not taken care of?
(Please be specific)

_____

_____

What would be different or better without these health issues?

__Diminished stress __Outlook

__Sleep __Confidence

__More energy __Family

__Work __Self-esteem

__Additional Info:_____

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is a part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

What are your strengths that will enable you to accomplish your goals?

_____

Rate on a scale of 1-10:

__________ How important is it for you to resolve your health concerns

__________ Do you feel that you are coachable and would enjoy a mentor in helping you?

__________ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank you!

Additional Notes:

____

____

____

- -

CONSENT

I have answered these questions to the best of my knowledge. I understand providing incorrect information can endanger my health. It is my responsibility to notify my provider of any change in my medical status, medications, or symptoms. I authorize the staff to perform the services that I need. Signature: __________________________Date:_________

Person completing if not client:_________________Relationship: __________

MISSED VISIT POLICY: Thank you for entrusting the Holistic Wholeness Institute with your health! Our goal is to help you reach a **full recovery**. Your practitioner will provide you with your plan of care during your evaluation and will inform you of the required plan of care to help you achieve your goal. *As experts, we know that you will not reach full recovery if you do not attend your appointments.*

To help ensure your best chance at recovery, we will work with you to schedule out your appointments, and you will need to attend each visit.

If you're running late for your appointment, you're missing the time that we specifically scheduled for your care. Please call us immediately so we can consult with your practitioner and prepare for your late arrival. If you are more than 15 minutes late, your session may need to be rescheduled. If that occurs, this visit will be counted as missed. If the visit was already prepaid, it will not be refunded; if it was not prepaid, your card on file will be charged for this visit the agreed-upon amount discussed by your practitioner.

While we understand that illness can strike at any time, we still expect that you will work to provide us with the 24 hours' / 1 business day notice that is required to reschedule your appointment. Please call Holistic Wholeness Institute during business hours at 732-813-1133 and have your calendar handy so we can reschedule you right away.

When you schedule an appointment with us, we set aside enough time to provide you with the highest quality of care. Our schedule is very full and certain time slots are not always available for other clients who need them. **Should you need to change a scheduled appointment, we require 24 hours' / 1 business day notice if a weekend/holiday precedes your appointment. This gives us time to schedule other clients who are waiting for an appointment. This paid visit will count as rendered if you do not provide at least 24 hours' notice of your appointment change or cancellation.** Clients who have multiple same-day cancellations or no-shows, will be removed from the schedule.

We require a credit card on file in the case that this policy must be implemented. Thank you for your cooperation.

CC#:_____ Exp Date:_____CVV#:_____

I have read the Holistic Wholeness Institutes's Missed Visit Policy and understand its terms.

Client Name (Print):_____ Client Signature:_____ Date:_____