Wellness Questionnaire

DATE_____

Name_____ Male/Female Ht_____ Wt_____ DOB_____

Address_____ City_____ ST_____ ZIP_____

PHONE – Best # to reach you_____Email:_____

Occupation:_____ Marital Status:_____ How many Children do you have?_____

Forms of Detox/Cleanses you've done: _____

Who can I thank for referring you to me? _____

Are you under the care of a Doctor? _____ If so, please explain _____

Doctor's Name: _____ Phone:_____

List all medications and supplements you currently take regularly (including over the counter)_____

_____

# of cups of coffee/black tea daily? _____ Do you smoke?_____ Do you use recreational drugs or alcohol?_____

# of bowel movements daily? _____ Do you strain? _____Do you use a stool softener/laxative/suppository? _____

Do you have hemorrhoids /rectal problems?_____ Have you ever had a barium enema?_____ If so, when?_____

_____

BY YOUR SIGNATURE BELOW YOU CONFIRM THAT YOU UNDERSTAND YOU ARE HERE TO BE EDUCATED REGARDING NATURAL HEALTH AND NOT TO BE DIAGNOSED OR HAVE A DISEASE TREATED:

BY YOUR SIGNATURE BELOW YOU ARE ALSO CONFIRMING THAT YOU UNDERSTAND THE FOLLOWING:

Wellness Senate Bill 577: I have read the attached notice and understand that the services provided by New Breath of Life, Inc. and/or Diane Malloy are in compliance with section 2053.6 of the Business and Profession Code of the State of California.

24 Hour Cancellation Policy: If you must cancel your appointment, please call at least **24 hours** in advance or you will be charged in full for the session. If there is no answer when you call you can leave a message and I will acknowledge that you have cancelled your appointment so that we may reschedule.

Signature_____ **Date**_____

Typical Breakfast:_____

Typical Lunch:_____

Typical Dinner:_____

Typical Snack:_____

Please complete and sign both sides of this form

Please understand this section is optional
Please check all that apply currently or have in the past

HEALTH HISTORY			HEALTH HISTORY			HEALTH HISTORY		
Allergies (enviro, drug or skin)			Diabetes			Liver disorders		
Always hungry			Digestive problems			Lung Disorder		
Anemia			Diverticulosis			Lupus		
Anorexia/Bulimia			Dizziness			Menstrual problems		
Arthritis			Double/blurred vision			Muscle/Joint pain		
Asthma			Earache			Muscle stiffness		
Back problems/pain			Eat when nervous			Neuropathy		
Bad breath			Edema/swelling			Pacemaker		
Bitter metallic taste			Excess Gas			Poor appetite		
Bladder disorders			Excessive hair loss			Prostate problem		
Bladder Infection			Fatigue			Seizures		
Bronchitis			Frequent colds			Sinus problems		
Burping			Headaches			Skin disease		
Chronic cough			Heart burn/acid reflux			Thrombosis		
Chronic fatigue			HEP-C / HIV / AIDS			Uterus disorder		
Colitis			Hemorrhoids			Uterus/ovary problems		
Cold sores			High/low blood pressure			Other severe conditions:		
Constipation			Insomnia					
Depression			Irritable bowel (IBS)					

If answered yes to any please explain_____
_____

PLEASE CHECK WHETHER YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Contraindications			Contraindications			Contraindications		
Severe Cardiac Disease			Ulcerative colitis			Recent colon surgery		
Aneurysm			Crohn's disease			Renal insufficiency		
Severe Anemia			Cirrhosis			Fissures/ Fistulas		
Current Rectal Bleeding			Currently Pregnant			Chemo/radiation treatment		
GI hemorrhage/perforation			Congestive Heart Failure			Cancer		
Severe hemorrhoids			Abdominal hernia			AIDS		
Severe diverticulitis			Uncontroled Hypertension			Other SEVERE Colon/Digestive issues		

If answered yes to any please explain_____
_____
_____

Have you had any recent surgeries?_____ **If yes, please explain**_____
_____

Are you currently taking the following medications Coumadin, Heparin, Plavix (blood thinners)?_____

	NO	YES		NO	YES		NO	YES
Organ or Tissue Transplant			Pacemaker, Stint or similar device/implant			Currently Pregnant		

Please read before signing: ***I have honestly answered all above questions and am not intentionally withholding information about my health.***

Signature_____ **Date**_____

Notice Designed to Comply with the State of California Guidelines in The Business and Professions code of the State of California - Section 2053.6

*** All clients must read, understand and sign this disclosure ***

It is the intent that services provided comply with Section 2053.6 to the Business and Professions code of the State of California. In compliance with this code, you must be advised:

A) There are NO licensed medical professionals or physicians at New Breath of Life, Inc. This means and implies that they cannot and will not:

(1) Conduct surgery or any other procedure on another person that punctures the skin or harmfully invades the body
(2) Administer or prescribe X-ray radiation to another person.
(3) Prescribe or administer legend drugs or controlled substances by an appropriately licensed practitioner.
(4) Recommend the discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner.
(5) Willfully diagnose and treat a physical or mental condition of any person under circumstance or conditions that cause or create a risk of great bodily harm, serious physical or mental illness, or death.
(6) Set fractures.
(7) Treat lacerations or abrasions through electrotherapy.
(8) Hold out, state, indicate, advertise, or imply to a client or prospective client that he or she is a physician, a surgeon, or a physician and a surgeon.

California State law allows any person to provide nutritional advice or give advice concerning proper nutrition which is the giving of advice as to the role of food and food ingredients, including dietary supplements. This state law does not confer authority to practice medicine or to undertake the diagnosis, prevention, treatment, or cure of any disease, pain, deformity, injury or physical or mental condition and specifically does not authorize any person other than one who is a licensed health practitioner to state that any product might cure any disease, disorder or condition. —California Business & Professions Code

I fully understand that New Breath of Life, Inc.'s Diane Malloy is a Natural Health Professional, not a medical doctor.

I understand that the services performed at New Breath of Life, Inc. are at all times to help me gain a better knowledge of health processes in general. This will help me toward self-care, self-responsibility, improved daily living, health promotion, and health unexploitability.

I understand that as a Natural Health Professional Diane Malloy/ *New Breath of Life, Inc.* may discuss, and/or sell nutritional supplements (vitamins and minerals, etc.), herbs and other nutrients for special dietary use as they pertain to the whole body (holistic) concept of health, and not in the context of any specific disease, ailment or condition.

I further understand that it is my sole responsibility to seek medical advice where necessary when making dietary changes and as to any potential for interaction between current medications and supplements or herbs I decide to take.

It is the intent of this office to be in compliance with the California State Law.

I acknowledge that I have read this disclosure and have been given a copy of this document. This information was provided to me in a language I can read and understand.

_____ _____

Client Signature Date