Lotus Wellness INT.
Wholistic Health and Wellness Coaching /Consultation Intake Form

Client's Email : _____ Client's Phone #:_____

Client's Full Name:_____ Date of Birth: ____/____/_____

This form covers additional information that was not obtained on the registration form.

Personal Information:

Occupation: _____

Ethnic background:_____

Do you have children? ☐ No ☐ Yes, How many and ages?_____

Do you have pets? Y N What type and how many?_____

Your Health & Wellness Goals:

Is there a specific health and wellness factor that brings you to this consultation today?

_____

What are your primary health and wellness goals and/or concerns?

_____

What would you like to accomplish regarding your health & wellness short term (1-6 months)?

_____

What would you like to accomplish regarding your health & wellness longer term (6 months-1 year)?

_____

Are there any obstacles or challenges that you believe may make it difficult to achieve your health and wellness goals?

_____

Health Conditions:

Indicate below if you have, or had, any of the following conditions:

Cardiovascular

☐ High blood pressure ☐ High cholesterol ☐ Heart attack or stroke ☐ Arrhythmia

Genital/Urinary

☐ Frequent yeast infections ☐ Urinary tract infections ☐ Urinary incontinence ☐ Kidney disease

Liver

☐ Hepatitis ☐ Cirrhosis ☐ Other

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Health Conditions, Continued:

Indicate below if you have, or had, any of the following conditions:

Digestive/ Gastrointestinal

☐ Low appetite ☐ Constant hunger ☐ Constipation ☐ Diarrhea -
☐ Frequent gas, bloating or cramping ☐ Acid reflux/heart burn/indigestion ☐ Frequent nausea
☐ Hiatal hernia ☐ Celiac's disease ☐ IBD, Cohn's or Ulcerative Colitis
☐ IBS (Irritable Bowel Syndrome)

Neurological/ Mental Status

☐ Anxiety or Depression ☐ Headaches/Migraines ☐ Dementia/Alzheimer's ☐ Multiple Sclerosis (MS)
☐ Fibromyalgia

Muscular, Skeletal, Joints

☐ Back pain ☐ Joint Pain, stiffness, swelling ☐ Frequent muscle cramps
☐ Arthritis, Rheumatoid ☐ Arthritis, Osteoarthritis ☐ Osteoporosis/Osteopenia

Endocrine

☐ Diabetes Mellitus Type 1 ☐ Diabetes Mellitus Type 2 ☐ Metabolic Syndrome ☐Hyperglycemia
☐ Hypoglycemia ☐ Thyroid disorder - ☐ Adrenal disorder

Immune System

☐ HIV/AIDS ☐ Sexually Transmitted Disease ☐ Lyme disease or other tick borne
☐ Frequent strep throat ☐ Food allergies or sensitivities ☐ Seasonal or environmental allergies
☐ Chemical sensitivity ☐ Anemia/ blood condition

ENT

☐ Sinusitis ☐ Ear infections/ tubes in ears ☐ Chronic Obstructive Pulmonary Disease
☐ Chronic bronchitis ☐ Asthma ☐ Emphysema ☐ Frequent colds, infections

Other Conditions

☐ Alcohol or substance abuse ☐ Epilepsy or seizures ☐ Eating disorder
☐ Skin condition (eczema, dermatitis, psoriasis, acne) ☐ Gout ☐ Chronic Fatigue syndrome
☐ Alopecia (female hair loss) ☐ Female hair growth on face/ chest ☐ Dental/ periodontal problem
☐ Dizziness, low blood pressure ☐ Unexplained weight gain or loss

OTHER:

☐ Accident/ injury: (describe) _____

☐ Other not listed: _____

☐ Surgery: (describe): _____

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Women's Health:

Do you have regular periods: ☐ No ☐ Yes

Age of your first period: _____ Date of last period: ___/___/____

Concerns:

☐ Painful periods ☐ Irregular/ absent periods ☐ Heavy periods/ excessive bleeding
☐ Premenstrual Syndrome (PMS) ☐ Endometriosis

☐ Other: _____

Do you take birth control: ☐ No ☐ Yes If so, what kind:_____

Are you in peri-menopause or post-menopause? ☐ No ☐Peri ☐Post If so, symptoms/ concerns?_____

_____

Do you use bioidentical or synthetic hormones? ☐ No ☐ Yes

Men's Health:

Do you have prostate issues/ concerns: ☐ No ☐ Yes

Do you use bioidentical or synthetic hormones? ☐ No ☐ Yes

Treatments, Medications & Supplements:

Are you currently being treated for a medical condition? ☐ No ☐ Yes
If yes, explain (list medications you are taking for this condition): _____

_____

List any other over the counter or prescription medications you are taking: _____

_____

Vitamin, mineral or other supplements (including probiotics, herbals, or botanicals): _____

_____

Allergies or sensitivities (food, drugs, seasonal, chemical, other): _____

_____

Lotus Wellness Institute- Wellness Coach & Consultant Jennifer
Email form to: lotuswellnessInstitute1@gmail.com
Or sign in website for more information /https://lotuswellnessinstitute.com/
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Recent immunizations/vaccinations:_____

When did you last take an oral antibiotic: _____

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Additional Health Information:

Weight History: _____

Current Weight: _____

Highest Weight:_____ *When?* _____

Lowest Weight: _____ *When?* _____

Goal Weight: _____ *Expected time frame to accomplish this weight:* _____

Lifestyle, Exercise, Sleep:

Describe your typical daily energy level? Low Mid High

What is your current stress level? Low Mid High

Do you engage in regular physical exercise? Yes No

Type of Exercise:_____ Frequency: _____

Do you have any physical conditions which limit your ability to exercise? Yes No

If yes, describe: _____

What do you think causes you stress? _____

What do you do to relieve stress? _____

How many hours do you sleep per night? _____ Do you wake feeling rested? Yes No

Do experience any sleep problems (getting to sleep, staying asleep, waking in the morning)? Yes No

If yes, describe: _____

What are your hobbies or interests? _____

Additional Comments:

Please share any other information you deem necessary so you can receive the best recommendation possible.

_____

_____

_____

_____

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