Your Wellness Begins Here

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Birth Date: _____ Birthplace.: _____ Work/Occupation: _____

_____

Are you currently under a doctor's care? YES ☐ NO ☐

If yes, who? _____

For what? _____

Rx Currently taking _____

_____

_____

Non-Rx currently taking _____

_____

_____

Are there any other healers, helpers, or therapies with which you are involved? If so, who and for what and how long

_____

_____

_____

_____

Focus:

What is your chief concern?

_____

What are your goals for your health/life? _____

_____

List any current symptoms or problems _____

_____

_____

What are three factors in your life that seem most important to your daily health?

1. _____
2. _____
3. _____

Women

Date of last menstrual period_____

Are your periods regular?_____

How many days is your flow_____

Painful or symptomatic periods? _____
Explain_____

When was your last PAP test?_____

Number of pregnancies?_____Deliveries_____Abortions_____Miscarriages_____

Review of Symptoms

Abdominal pains ☐	aging rapidly ☐	Anemia ☐	arm, shoulder or leg problems ☐
Arthritis ☐	Asthma ☐	Back pain ☐	bad breath ☐
Bedwetting ☐	Birth control ☐	Blackouts ☐	Bladder or kidney infections ☐
Blood in urine ☐	Blood transfusion ☐	Bloody or black stools ☐	
Bone or Joint pain ☐	Breast lumps or pain ☐	Bruise easily ☐	Drug reaction ☐
Earaches ☐	Eczema ☐	Epilepsy ☐	Fatigue ☐
Fevers ☐	Gas ☐	Gonorrhea ☐	Headaches ☐
Hemorrhoids ☐	Hepatitis ☐	High Blood Pressure ☐	
Hives ☐	Hypoglycemia ☐	Increased Sexual Desire ☐	
Irregular bowel movements ☐		Itching ☐	Jaundice ☐
Joint swelling ☐	Kidney infection ☐	Leg swelling ☐	Low blood pressure ☐
Measles, German ☐	Measles, regular ☐	Mental Breakdown ☐	Migraine ☐
Mucous Problems ☐	Mumps ☐	Burning on urination ☐	
Cancer ☐	Chest pains ☐	Chicken pox ☐	Coated tongue ☐
Cold hands and/or feet ☐	Colitis ☐	Confusion ☐	Constipation ☐
Cough ☐	Coughing blood ☐	Decreased sexual desire ☐	
Diabetes ☐	Diarrhea ☐	Difficult digestion ☐	Difficulty breathing ☐
Diphtheria ☐	Dizziness ☐	Muscle cramps ☐	Muscle tension ☐
Nasal congestion ☐	Neck pain ☐	Nervousness ☐	Nightmares ☐
Nosebleeds ☐	Number of BM's ☐	Obesity ☐	Parasites ☐
Pneumonia ☐	Polio ☐	Poor endurance psoriasis ☐	
Psoriasis ☐	Rheumatic fever ☐	Ringing in the Ears ☐	
Shortness of Breath ☐	Sinus Pressure ☐	Skin Boils ☐	Skin rashes ☐
Sore Throat ☐	Sores in throat ☐	Teeth or gum problems ☐	
Tongue problems ☐	Tuberculosisi ☐	Ulcer ☐	Urinary problems ☐
Weight loss or gain ☐	Whooping cough ☐		

Do you have allergies?_____
If yes to which Medicines_____
To which Foods_____
To what in the environment_____
Do you take any regular vitamin, mineral or herbal supplements not listed on the first section_____
_____
_____

Have you had any operations?__please list when and what year_____
_____
_____

Any major injuries/accidents? What and when?_____
_____

Any other information not covered above?_____

Family History

List birthdates and health status of immediate family: Write AW if they are alive and well. List any chronic illness/es they have, or if deceased, mark D and list the cause.

Relationship	Birth Date	Health or if Deceased, Cause
Mother		
Father		
Sister/s		
Brother/s		

Do any of these illnesses/situations run in the family? Who?

☐ Diabetes_____ ☐ Cancer_____

☐ High Blood Pressure_____ ☐ Epilepsy_____

☐ Heart Disease_____ ☐ Mental Illness_____

☐ Tuberculosis_____ ☐ Thyroid Problems_____

☐ Asthma_____ ☐ Obesity_____

☐ Gout_____ ☐ Twins_____

Diet and Excercise

Do you have a good appetite?_____

Are there one or more particular food flavors that you crave?
Sweet☐ Salty☐ Spicy☐ Bitter☐ Sour☐ Other_____

Fill in the average times in a week you consume the following in your diet
Coffee_____Nicotine_____Alcohol_____Drugs_____

Do you exercise?_____ If so, how often?_____

What type-i.e. walking?_____

General Questions

How do you feel about yourself and life?_____
_____
_____

Is there much stress in your life?_____

If so, what does it surrount? i.e. family, work, finances, relationships, etc…Explain_____
_____
_____

Do you sleep well?_____How many hours a night?_____

Referred by

Where you referred by someone?_____If so, who?_____

Pamela Owens, N.D., C.N.H.P

"Avatar"

Electrodermal Screening

Notice of Understanding and Agreement

I understand that I am not consulting for medical, diagnostic or treatment procedures. The services performed at this clinic are at all times restricted to helping me gain a better understanding of my level of bio-energetic health so that I will have a greater self-awareness and be able to use a self-care program

I understand that the recommendations, discussion, sale of nutritional supplements or homeopathics pertains to the "whole body" energetic concept of nutrition and does not relate in the context of any specific ailment or condition.

The appointments do not involve the diagnosing, prognostication, treating or prescribing of medicines for the treatment of disease, or nay act which will constitute the practice of medicine in the state, for which a license is required.

Name:_____ Date:_____

Signature:_____

Witness_____

Consent to Evaluate a Minor Child

Minors Name_____

Parent/Guardian:_____

Relation_____

Witness_____

Pamela Owens, N.D., C.N.H.P.

Nutritional Client Statement

I hereby attest to the following:

I fully understand the Pamela Owens is not a medical doctor or practitioner that does not diagnose or treat disease, and that I am not here for medical diagnostic or treatment purposes.

The services performed by Pamela Owens, whether in person or by mail, email or by phone, are at all times restricted to consultation of the subject or nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment of prescribing of remedies for the treatment of disease.

I understand that it is my constitutional right to decide how I wish to care for the health of my body. Pamela Owens has not suggested that I cease current medical care I am receiving, be it drug therapy, x-ray treatments. Chemotherapy, surgery, or any other medical procedures that my medical doctor deems necessary to my health. If I choose to not follow recommendations made by my medical doctor, I understand that such a decision is my responsibility and will not hold Pamela Owens responsible for any consequences of such a decision.

I am here, or this and any subsequent visit, solely on my own behalf and not as an agent for federal, state, or local agencies on a mission of entrapment or investigation.

Date_____

Signed_____

Name_____

Please print

Address_____

City_____State_____Zip_____

Telephone_____Cell_____

Email_____