

Rosen Wellness
Consultation Assessment

General Information:

Name: _____ Date: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Age: _____ Date of Birth: _____ Guardian (if under 18): _____

Gender: M F Height: ___' ___" Weight: _____ lbs. Blood Type _____

Emergency contact & phone: _____

Occupation: _____ Employer: _____

How did you hear about Rosen Wellness? _____

Major complaint(s) in order of significance to you:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

How do these conditions affect your daily activities? _____

Why are you seeking a consultation? If you have any specific health condition, please describe it in detail including the first time you noticed the condition.

Medical History:

List any medications (prescription and/or over the counter) that you are *currently* taking.

Medication:	For what:	Dosage:	Taking for how long:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

List any nutritional supplements and/or herbs you are *currently* taking.

Supplement/Herb	For what:	Dosage:	Taking for how long:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Please list any major surgeries you have had and approximate dates:

Surgery	For what:	Date:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Have you taken antibiotics within the past six months? _____
How frequently have you taken antibiotics during your life? _____

How many bowel movements do you average per day? _____

Describe the condition of your skin (without lotion): Very dry Dry Normal Oily

- | | |
|--|---|
| Female: Please check all that pertain: | Male: Please check all that pertain: |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Difficulty with erection |
| <input type="checkbox"/> Loss of periods | <input type="checkbox"/> Loss of libido |
| <input type="checkbox"/> Birth control pills (when and how long _____) | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> IUD | |
| <input type="checkbox"/> Yeast infections | |
| <input type="checkbox"/> Menopause | |
| <input type="checkbox"/> Painful intercourse | |
| <input type="checkbox"/> Children | |
| <input type="checkbox"/> Hysterectomy | |

List any food allergies, restrictions, or sensitivities you are aware of:

Please place an "X" next to all of the following substances that you use and/or consume:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Tap Water | <input type="checkbox"/> Packaged Food |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> NutraSweet/Sweet n' Low |
| <input type="checkbox"/> Tea | <input type="checkbox"/> Candy |
| <input type="checkbox"/> Soft Drinks | <input type="checkbox"/> "Normal House Cleaning Products
(<i>not</i> "green" products) |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> "Normal" Cosmetics (<i>not</i> health
food store types) |
| <input type="checkbox"/> Laxatives | |
| <input type="checkbox"/> Hair Dyes | |

Dietary Habits: Are you vegetarian or vegan? (Circle either if yes)

Number of snacks during the day: _____

Describe your typical snack(s): _____

What beverages do you usually drink and how much per day? _____

Do you ever buy organic foods? Never Sometimes Usually Always

What do you buy organic: Fruits Vegetables Meat Dairy Boxed Canned Frozen

How many meals do you eat out at restaurants during a typical week? _____

How many are at fast food restaurants? _____

Do you crave any of the following?

- | | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Meat Fat | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fish | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Desserts | <input type="checkbox"/> Milk | <input type="checkbox"/> Bread | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Other _____ |

Which oils do you use/consume?

- | | | | | | |
|--------------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola | <input type="checkbox"/> Margarine | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise | <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Flaxseed Oil |
| <input type="checkbox"/> Soybean Oil | <input type="checkbox"/> Other _____ | | | | |

The dairy products I eat are mostly (circle one):

Full fat Low fat Skim I don't eat dairy products

My intake of artificial sweeteners is (circle one): Frequent Occasional Infrequent

Do you smoke cigarettes or use other tobacco products? Y N

For the purposes of the following question a drink is considered to be a 12-ounce beer, a four ounce glass of wine, or a shot of hard liquor. On an average day I have:

No drinks 1 drink 2 drinks 3-4 drinks More than 4 drinks

How often do you eat the following foods? (Use the **past three months** as your time frame)

GRAINS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Refined grains: White bread, wheat bread (not whole grain), tortilla, roll, biscuit, muffin, English muffin or bagel							
b. Cooked cereal							
c. Cold cereal							
d. Refined grains: White rice or white pasta							
e. Whole grains: 100% whole grain bread, brown rice, whole wheat pasta, or other whole grains (such as quinoa, buckwheat, amaranth, millet, barley)							

FRUITS AND VEGETABLES	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Cooked vegetables							
b. Raw vegetables							
c. Potato (white)							
d. French fries							
e. Piece of fruit / berries or raisins							

DAIRY/FATS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Cheese (hard cheese, cream cheese)							
b. Yogurt and/or kefir							
c. Ice cream							
d. Margarine							
e. Salad dressings, mayonnaise							
f. Soy based "dairy" products							
g. Butter							
h. Olive oil							
i. Coconut oil							

PROTEINS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day
a. Red meat (beef, bison)						
b. Pork, ham, bacon						
c. Poultry (chicken, turkey, duck)						
d. Fish or seafood						
e. Nuts and/or seeds						
f. Soy based protein						
g. Pizza						
h. Eggs						
i. Protein smoothie (whey, rice, pea)						

SWEETS AND SNACKS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Sweet roll, doughnut, pie, cake or cookies							
b. Candy or candy bar							
c. Salty snacks (chips, pretzels, crackers)							

How long have you eaten this way? _____

Lifestyle:

During a typical day at home and at work I will be sitting (at my desk, in a meeting, in a chair, on a couch) for about _____ hours.

I exercise usually exercise _____ days per week.

If you do exercise, please indicate in which forms of exercise you participate.

On days that I exercise my workout is usually _____ minutes.

Please rate the following:

Daily energy level: Excellent Good Fair Poor

Energy level after exercise: Excellent Good Fair Poor

Stress:

Are you happy with your family life? Yes No

Are you happy with your work life? Yes No

Daily stress level: Very High High Moderate Low None

Do you ever eat or drink to satisfy your emotions? Yes No

Do you have a support system of family and friends? _____

What creates stress in your life? _____

How many hours do you sleep? _____ Do you sleep throughout the night? _____

Do you wake up feeling rested? _____ Do you fall asleep within 15 minutes? _____

Have you ever been on a restricted or specific diet program? Yes No

If yes, what program and what were the results? _____

Please read the following paragraph:

Restoring the body and resolving specific complaints is an ongoing process that will take some time. It is important to understand that your diet and lifestyle directly impacts both your current state of health and your future state of health. My role is to educate you and to offer ideas and recommendations that may help improve your health. However, your health is your responsibility. Therefore, you must be willing to accept full responsibility for your health. Part of this responsibility will be the requirement to prepare more meals at home, eat healthier foods, and live a healthier lifestyle.

Client Authorization:

I understand that Bernard Rosen is not a medical doctor, nor does he prescribe pharmaceutical drugs, nor does he provide medical diagnosis or surgery. He provides holistic nutritional consulting and education utilizing assessments, tests and counseling. The holistic health care philosophy is to do no harm, work on prevention, work on the root of the problem, and work on the whole person. I understand that holistic health care is not intended as diagnosis, prescription, treatment or cure for any disease, mental or physical, and is not a substitute for regular medical care.

I request that Bernard Rosen perform an evaluation and set up a program for the purpose of enhancing my health and education. Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care. This includes the right to choose my diet, and to obtain, purchase and use any therapy, regimen, modality, remedy or product recommended by the therapist, doctor, or any practitioner of my choice. The enumeration in this declaration of these rights shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.

It will be important that I am involved with my health care and health choices. I understand that all recommendations provided by Bernard Rosen are not intended as treatment or prescription for any disease, or as a substitute for regular medical care. It is important that I continue to communicate with all my doctors during our consultations. It is important that I understand that I am a partner in this process. By signing the form I agree and give Rosen Wellness, LLC my permission to release any information and/or reports to other healthcare professionals in regards to my care.

By signing below, you acknowledge that any dietary or supplemental suggestions made by Bernard Rosen are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

I have read the statements above and understand completely and am willing to play an active role in achieving my health related goals:

Client sign and date:
