Fresh Start WELLNESS

CASEY GRANT
HOLISTIC WELLNESS PRACTITIONER

WWW.FRESHSTARTWELLNESSAZ.COM
O: 480-663-3020
C: 602-684-2001

Date:

INFORMATION

Name: | | |
LAST | FIRST | MI

☐MALE ☐FEMALE ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

Date of Birth: _____ Number of Children: _____

Occupation: _____ Height: _____

Address: _____ Weight: _____

ADDRESS LINE 1

PHONE:

HOME: _____

ADDRESS LINE 2

WORK: _____

CITY ST ZIP CODE

E-Mail: _____ CELL: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

Referred By:

Did You Hear About Us Through Phone or Business Directory? ☐YES ☐NO	Did You Hear About Us Through Advertisement? ☐YES ☐NO
If "Yes" Where?	If "Yes" Where?

PERSONAL HEALTH HISTORY

What is the purpose of your visit?

☐ WELLNESS/NUTRITION
☐ ZYTO
☐ WEIGHT LOSS
☐ HYPNOTHERAPY
☐ SUPPLEMENTS
☐ OTHER

Please list any health conditions that you have been treated for in the last year: _____

Have you had previous chiropractic care? ☐YES ☐NO

Condition(s) Treated For: _____

Date of Last Chiropractic Visit: Are you Pregnant? ☐YES ☐NO

LIST CURRENT MEDICATIONS:

Name Medication	Amount	Frequency	Length of Use	Reason for Use

LIST CURRENT VITAMINS, MINERALS, SUPPLEMENTS AND HERBS:

Name Medication	Amount	Frequency	Length of Use	Reason for Use

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PERSONAL INCIDENT HISTORY:

Had major sprains/strains/broken bones? ☐YES ☐NO If "Yes," did you receive professional care/treatment? ☐YES ☐NO

If "Yes" briefly explain: _____

Have you ever been hospitalized? ☐YES ☐NO If "Yes" briefly explain: _____

Have you ever had surgery? ☐YES ☐NO If "Yes" briefly explain: _____

Had major sprains/strains/broken bones? ☐YES ☐NO If "Yes," did you receive professional care/treatment? ☐YES ☐NO

If "Yes" briefly explain: _____

Have you been diagnosed with an eating disorder? ☐YES ☐NO If "Yes" briefly explain: _____

Have you ever been struck unconscious? ☐YES ☐NO Have you had a stroke? ☐YES ☐NO

SOCIAL HISTORY AND LIFE CHOICES

Alcohol:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER	Caffeine Drinks/Products:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER
Water:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER	Drugs:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER
Exercise:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER	Energy Products/Over-the-counter stimulants:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER
Fresh and Homemade Foods:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER	Processed, Packaged and Restaurant Foods:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER
Soft Drinks:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER	Tobacco:	☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ NEVER

HEALTH PROBLEMS AND CONCERNS (CHECK ALL THAT APPLY)

☐ ALCOHOL	☐ CRAMPS	☐ HIGH BLOOD PRESSURE	☐ RETINAL DISEASE
☐ ALLERGIES	☐ CVA (STROKE/TIA)	☐ HOT FLASHES	☐ SCIATICA
☐ ANEMIA	☐ DEMENTIA/ALZHEIMER'S	☐ IRREGULAR HEART BEAT	☐ SEIZURES
☐ ASTERIOSCLEROSIS	☐ DEPRESSION	☐ KIDNEY INFECTION	☐ SHORTNESS OF BREATH
☐ ARTHRITIS	☐ DIABETES	☐ LIVER INFECTION/CIRRHOSIS	☐ SINUS INFECTION
☐ ASTHMA	☐ DIGESTIVE PROBLEMS	☐ LOSS OF MEMORY	☐ SLEEP PROBLEMS/INSOMNIA
☐ AUTOIMMUNE DISEASE	☐ DIAGNOSED MENTAL DISORDER	☐ LOSS OF BALANCE	☐ SKIN SENSITIVITY
☐ BACK PAIN	☐ DIZZINESS	☐ LOSS OF SMELL	☐ SMOKED
☐ BLEEDING DISORDERS	☐ EPILEPSY	☐ LOSS OF TASTE	☐ SPINAL CURVATURES
☐ BREAST LUMP	☐ EXCESSIVE MENSTRUATION	☐ LUNG DISEASE	☐ STROKE
☐ BRONCHITIS	☐ EYE PAIN OR DIFFICULTIES	☐ MACULAR DEGENERATION	☐ SWELLING OF ANKLES
☐ BRUISE EASILY	☐ FATIGUE	☐ MIGRAINES	☐ SWOLLEN JOINTS
☐ CANCER	☐ FREQUENT URINATION	☐ NOSEBLEEDS	☐ THYROID CONDITION
☐ CATARACTS	☐ GALLBLADDER DISEASE/STONES	☐ PACEMAKER	☐ TUBERCULOSIS
☐ CHEST PAIN	☐ GLAUCOMA	☐ PARKINSON'S	☐ ULCERS
☐ CHF (CONGESTIVE HEART DISEASE)	☐ GOUT	☐ POLIO	☐ VARICOSE VEINS
☐ COLD EXTREMITIES	☐ HEADACHE	☐ POOR POSTURE	☐ VENEREAL DISEASE
☐ CONSTIPATION	☐ BULIMIA	☐ HEARING PROBLEMS	☐ OTHER
☐ COPD/EMPHYSEMA	☐ HEMORRHOIDS	☐ PROSTATE TROUBLE	

Do you have Diabetes? If so, what type? ☐ TYPE I ☐ TYPE II ☐ JUVENILE Do you have stomach/digestive issues? ☐YES ☐NO

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Is there a behavior in your lifestyle that you feel is the most important to change?

HEALTH GOALS
Goal #1:
Goal #2:
Goal #3:

Terms & Agreement

Fresh Start Wellness, LLC, products, programs, website, and services are not intended to replace medical treatment of any kind. We recommend consulting your doctor prior to making any changes to your diet, exercise, lifestyle, medications and/or supplementation. By accepting services you acknowledge, understand and agree that you are doing so on your own initiative and at your own risk and that in doing so, your health decisions are your responsibility and not the responsibility of Fresh Start Wellness, LLC. While the information conveyed in our programs and services and on our website were prepared to provide accurate information regarding topics related to general and specific health and wellness, the information is made available with the express understanding that Fresh Start Wellness, LLC is not dispensing medical advice and do not intend any of their information to be used for diagnosis or treatment. If you have any questions or concerns about your health and before starting or stopping any treatment or acting upon information related to any of our products and services, you should contact your own physician or health care provider.

By signing below I acknowledge I have read and understand the Terms and Conditions above.

Signature: _____ Date: _____