**WELLNESS CONSULTATIONS**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please complete this entire packet along with:**

* **Any lab work from your medical record.**
* **A list of any current medications you are taking.**
* **A list of any supplements you are currently taking.**

**Please bring this completed nutrition packet and any additional forms to your initial consultation.**

**Reminder: If you need to cancel or reschedule your appointment, please do so 24 hours or more in advance of your scheduled appointment time or you will be charged a $85 cancellation fee.**

Waiver and Release for Wellness Consultations,

herbal supplementation and general product usage

We strongly suggest that you consult a Physician before undergoing any dietary or food supplement changes. Any recommendations you follow for changes in diet, including but not limited to the use of food supplements, are entirely your responsibility. The Stress Reduction Group LLC, Luminat Radiant Wellness, and all agents do not diagnose or treat disease. Wellness consultations are implemented to identify imbalances and suggest alternative ideas to enable the body to heal. We do not claim to be a physician, nutritionist or any other type of medical professional to diagnose the presence or absence of disease. Wellness consultations and supplementation does not take the place of seeing a physician and is not designed to cure or treat disease as these are merely suggested ideas to be applied as an overall wellness protocol for healthy living.

In My participation in any wellness consultation, service or purchase of products dietary or otherwise I hereby accept all risk to my health and of my injury or death that may result from such participation and I hereby release the above named Institution, its governing board, officers, employees and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation in wellness consultations, participation in bodywork services, purchase and use of suggested products or tools whether caused by negligence of the above named institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the above named institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described wellness consultation and its suggested action plan.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR MY INJURY OR DEATH OR DAMAGE TO MY PROPERTY THAT OCCURS WHILE PARTICIPATING IN WELLNESS CONSULTATIONS,PURCHASE AND USE OF ANY PRODUCTS SOLD OR SUGGESTED TO ME BY THE STRESS REDUCTION GROUP, LLC,THE STRESS REDUCTION CENTER FOR HEALTH MANAGEMENT, LUMINAT RADIANT WELLNESS OR ANY OF ITS AGENTS OR REPRESENTATIVES, AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY MY NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

Signature of Client Date

New Client Registration

|  |  |  |
| --- | --- | --- |
| Name |  | |
|  |  | |
| Home Address |  | |
| Street | |
| City | Zip |
|  |  |  |
| Contact Information  (✓ check preferred method of contact) |  |  |
| Home Phone | Cell Phone |
| Work Phone | Email address |
|  |  |  |
| Occupation |  | |
| Employer |  | |
|  |  |  |
| Individual responsible for charges |  |  |
| Name | Phone number |
|  |  |  |
| Referred by |  | |
| Referral reason |  | |
|  |  |  |
| Current Physician |  | |
| Name | Phone number |

# Acceptance of Registration Information

I hereby accept the registration information written above as accurate and acknowledge this information will be used to guide the us in preparing my personalized plan of care.

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*Signature of New Client Date*

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| Nutrtion History Questionairre   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Client Name: | | |  | | | | | | | Age: |  | | | | | Gender: |  | | | Height: | |  | | Present Weight: |  | | | |  | | | | | | | | | | I. GENERAL INFORMATION | | | | | | | | |   Describe your typical eating environment (e.g. alone, with a spouse or roommate, in car, at desk):  Vitamin/mineral supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Weight loss, herbal, or sports supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you now or have you ever followed any special diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If so, what type of diet?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How often do you eat out? \_\_\_\_\_\_\_\_times per week. What type of restaurants?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Food likes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Food dislikes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have any food allergies or intolerances? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What happens if you eat these foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are there any foods that you do not eat at all? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you have any problems with:   * Chewing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Swallowing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Nausea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Vomiting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Diarrhea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Constipation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Acid reflux (heartburn)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Do you smoke or use tobacco products? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| II. Weight History | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you ever tried to lose weight? | | | | | | | | | |  | | | | YES | | | | | |  | | NO | | | | Number of attempts: | | | | | | | | | | |  | | | | |
|  | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| What was your weight (in lbs): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 year ago | |  | 3 years ago | | | | | |  | | 5 years ago | | | | | | | | | | | | |  | | | | | | 10 years ago | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | |  | | |  | | | | | |  | |  | | | | | | | | | | | | | | |
| Have you ever used laxatives for weight control? | | | | | | | | | | | | | | | |  | | | YES | | | | | |  | | NO | | | | | | | | | | | | | | |
| Have you ever vomited for weight control? | | | | | | | | | | | | | | | |  | | | YES | | | | | |  | | NO | | | | | | | | | | | | | | |
| Have you ever used supplements for weight control? | | | | | | | | | | | | | | | |  | | | YES | | | | | |  | | NO | | | | | | | | | | | | | | |
| Do you have a goal weight that you would like to weigh? \_\_\_\_\_\_\_\_\_\_\_If so, what is the weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| III. Medical History | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of last physical exam: | | | | | |  | | | | | | | | | | | Are Lab results available? | | | | | | | | | | | | | | | |  | | YES | | | |  | NO | |
| Physician/Medical Professional: | | | | | | | |  | | | | | | | | | | | | | | | | | | Phone Number: | | | | | | | |  | | | | | | | |
| Medical condition(s)/  health problem(s): | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please complete the following concerning any medications you take: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medication | | | | | Dosage | | | | | | | | | | | | | | | How long have you taken this medication? | | | | | | | | | | | | | | | | | | | | | |
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| Have you ever been advised by your Physician to follow any type of diet? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If ‘YES’, what type: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What changes did you make at that time? | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| IV. Exercise History | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Which of the following primarily describes your work or daily activity? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sitting | | | | | |  | Walking or other active motion | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Standing | | | | | |  | Heavy labor (such as heavy lifting) | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you currently exercise 20 minutes or more, outside of daily tasks? | | | | | | | | | | | | | | |  | | | YES | | | | | | | |  | | | NO | | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | If you answered ‘yes’, how often each week do you exercise? | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| What type of exercise? | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| V. For Women | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is your menstrual cycle regular? | | | | | | | | | | | | |  | | YES | | | | | |  | | NO | | | | |  | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| Are you pregnant or nursing? |  | YES |  | NO |  |

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|  |
| VI. Conclusion |
|  |

What are your goals or expectations for your wellness consult?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hereby certify that the information above is complete and accurate.

*Signature of Client Date*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dietary Intake** | | |  | | | |  | | |
| ***Food Groups*** | | | ***# Servings per day*** | | | | ***# Servings per week*** | | |
| Breads, cereal, pasta, rice, other grains | | |  | | |  | | | |
| Fruits | | |  | | |  | | | |
| Vegetables | | |  | | |  | | | |
| Milk, cheese, yogurt | | |  | | |  | | | |
| Meat, poultry, fish, eggs | | |  | | |  | | | |
| Lentils, beans, tofu | | |  | | |  | | | |
| Peanut butter, nuts | | |  | | |  | | | |
| Fats such as margarine, mayonnaise, sour cream | | |  | | |  | | | |
| Oils | | |  | | |  | | | |
| Fried foods or salty snack foods such as chips | | |  | | |  | | | |
| Desserts | | |  | | |  | | | |
|  | | | | | | | | | |
| **Products** | | | | ***# Servings per day*** | | | | ***# Servings per week*** | |
| Sweet beverages such as soda or fruit drinks | | | |  | | | |  | |
| 100% fruit juice | | | |  | | | |  | |
| Alcohol | | | |  | | | |  | |
| Water | | | |  | | | |  | |
| Caffeine beverages such as soda, coffee, tea, or energy drinks | | | |  | | | |  | |
| Sports products such as drinks or bars | | | |  | | | |  | |
| Chewing gum | | | |  | | | |  | |
|  | | | | | | | | | |
| **Behaviors Past or Present** | | | | | | | | | |
| ***Behavior*** | ***Yes*** | ***No*** | | | ***Frequency*** | | | | ***Most recent*** |
| Count calories |  |  | | |  | | | |  |
| Count fat grams |  |  | | |  | | | |  |
| Dieting |  |  | | |  | | | |  |
| Diet pills |  |  | | |  | | | |  |
| Binge eating |  |  | | |  | | | |  |
| Fat restriction |  |  | | |  | | | |  |
| Fluid restriction |  |  | | |  | | | |  |
| Discomfort with your body size |  |  | | |  | | | |  |
| Other |  |  | | |  | | | |  |

11

# Authorization for Release of Information

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| --- | --- | --- | --- |
| I authorize |  | | |
|  | Name of physician, agency or institution | | |
|  | Address | | |
|  | City | State | Zip |
|  | Phone Number | | |
| To exchange records with | **Heather Shells, LMT, CKTP** | | |
|  | Representative of The Stress Reduction Group, LLC/Luminat Radiant Wellness | | |
|  | 700 Godwin Avenue Suite 220 | | |
|  | Address | | |
|  | Midland Park NJ 07432 | | |
|  | City | State | Zip |
|  |  | 2019549107 |  |
|  | Phone Number | | |
| In regard to |  | | |
|  | Name of Client/Patient | | |

## Signature of Responsible Party Date