



Nutritional Wellness Coaching
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Name: _____ E-Mail Address: _____
Street Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Date of Birth: _____ Place of Birth: _____
Age: _____ Gender: _____ Height: _____ Weight: _____
Would you like your weight to be different: Y N If so, what? _____ Blood Type: _____
Occupation: _____ How many hours do you work per week? _____
Relationship Status: _____ Children: Y N How Many? _____

Who may I thank for referring you? _____

Describe the symptoms you are currently experiencing and when they started? _____

What would you like to accomplish/gain from this consultation? _____

Do you sleep well? Y N Do you wake up during the night? Y N If so, what time(s)? _____

What time do you go to bed? _____ What time do you usually wake up? _____

How do you feel when you wake up? _____

Do you drink caffeinated drinks? Y N What kind, how much, and how often? _____

Do you smoke? Y N If yes, how much and how often? _____

If no, did you recently quit and how? _____

Do you drink alcohol? Y N How much and how often? _____

Do you drink soda? Y N If so, diet or regular? _____ How much and how often? _____

Do you drink energy drinks or Gatorade? Y N How much and how often? _____

How often do you exercise? _____ Type of exercise? _____

How much water do you drink per day? _____ Is it tap water? _____

Do you use sugar substitutes? Y N

Please list any vitamins/minerals, herbal or homeopathic remedies, prescription drugs, over-the-counter medications, ingested oils or any other supplements you are currently taking: _____

Do you have any known allergies to medications or herbs? Y N Please list all below: _____

Are you currently under a doctor's care for a specific health issue? If so, what issue and what treatments are you currently undergoing? _____

Please list the name and date of any surgeries, accidents, injuries or childhood diseases for which you've received treatment: _____

Were you ever diagnosed with Mononucleosis: Y N

What are your top three health and wellness goals?

1. _____
2. _____
3. _____

Are you willing to change the way you eat to attain these goals? Y N

Are you willing to take supplements to attain these goals? Y N

Will other members of your household support a health and lifestyle change for you? Y N

Have you recently gone through a serious life change such as a divorce, loss of a loved one, moving to a new home? Y N Please give a short explanation: _____

On a scale of 0 to 5, how stressful is your life right now? 0 1 2 3 4 5 Off the chart!

Do you buy organic fruits and vegetables? _____ What percentage? _____
What types of foods did you eat as a child? _____

What percentage of your food is home cooked? _____
How often do you eat out? _____ What is your favorite restaurant? _____
What are the three healthiest foods you eat each week? _____

What are the three worst foods you eat each week? _____

Is there any food you would be unwilling to give up? Y N What? _____

Do you crave sugar? Y N Do you crave salt? Y N Do you ever have heartburn or GERD? Y N

Do you feel tired, bloated and/or gassy after meals? Y N

Do you experience constipation or diarrhea? Y N

How often? _____ When? _____

Do you feel excessively hungry? Y N Do you have a poor appetite? Y N

Please list any known food allergies, intolerances or foods you cannot currently eat: _____

Family Health History

Please list any significant genetic health concerns or conditions that run in your family? _____

Women Only

Age of your first period: _____ Are your periods regular? Y N

How frequent: _____ How many days is your flow? _____

Do you experience PMS: Y N Is it mild or severe? _____

Are you peri-menopausal? Y N When did this change first occur? _____

Are you menopausal? Y N When was your last period? _____

List any symptoms of peri/menopause: _____

Number of pregnancies: _____ Did you receive antibiotics during labor? Y N

How many children have you delivered by vaginal birth? _____ Cesarean birth? _____

Men Only

Approximate age of onset of puberty: _____ Do you feel your libido is adequate? _____

Do you wake at night to urinate? Y N If so, how many times? _____

Do you have any difficulty and/or pain with urination? _____ Diminished volume or flow? _____

Do you enjoy daily activities? Y N

Do you feel apathetic or complacent about previously enjoyed activities? Y N

Do you notice feeling more agitated/irritable than previously in your life? Y N

Vaccination History:

Children: Is your child up to date on vaccines? Y N When/what was their last vaccine? _____

Adults: When/what was your last vaccine? _____

Do you get a flu shot? Y N Pneumonia shot? Y N

Did you get a Shingles vaccine? Y N Did you get the Covid vaccine? Y N Which one? _____

How often have you taken oral steroids or antibiotics? _____

Is there anything else you would like to add that might be helpful for me to know?

AGREEMENT AND RELEASE OF LIABILITY

The health and nutritional information you receive from Jennifer Myers of Nutritional Wellness Coaching, LLC, whether by phone, in person at your home, in the office, through lectures, workshops, brochures, emails, or newsletters is not intended to diagnose, prescribe, treat, cure, alleviate, prevent or care for any disease in any way. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as patient results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a clinician or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body and who has experience in treating immune disorders and other health imbalances. Please be aware that you have the right to make your own health decisions based on any information made available to you. YOU are the driving force in guiding yourself on a path to health!

ACKNOWLEDGEMENT

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by Jennifer Myers of Nutritional Wellness Coaching, LLC is to be used for educational purposes only. I acknowledge that Jennifer Myers does not claim to be a medical doctor and will not prescribe for or diagnose, treat, prevent, alleviate or cure any disease or condition.

If I experience any changes in my health or current medications, I will immediately communicate this information to Jennifer Myers. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Jennifer Myers liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

I understand that Muscle Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems. I understand the Muscle Response Testing is not a method for diagnosing or treating any disease including conditions of cancer, AIS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Muscle Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Muscle Response Testing is a meant by which the body's natural reflexes can be used as an aid to determine possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

In consideration of being allowed to participate in programs and activities of Nutritional Wellness Coaching, LLC and to use its facility in addition to the payment of any fee or charge, I do hereby waive, release, and forever discharge Nutritional Wellness Coaching, LLC from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment. I do also hereby release Nutritional Wellness Coaching, LLC from any responsibility or liability from any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or those acting on their behalf or in any way arising out of or connected with my participation in any activities at Nutritional Wellness Coaching LLC. I have read and understand the foregoing. Intending to be legally bound, I hereby release Nutritional Wellness Coaching LLC from any liability, including for negligence regarding my health matters and my participation in Muscle Response Testing and Nutritional Therapy. This release applies to all subsequent visits for consultations and activities at Nutritional Wellness Coaching LLC.

Client Name (Print): _____

Client Guardian Name if client is a minor (Print): _____

Client/Guardian Signature: _____

Date: _____