Wellness Coaching

Name:____ Date:____________________________________

New Client Registration Form

All information on this form is confidential. If you are uncomfortable answering any questions, or if they do not apply, you may leave them blank and discuss them with your practitioner. Please print clearly.

Personal Information

Full Name ____________________________________
Gender Identity _______________________________
Date of Birth___________Time of Birth______________
Phone Numbers: Home_________________________
Cell Phone ____________________
Work _________________________
Address
____
____
____

Emergency Contact_____________________________
Who referred you here?__________________________

Do you have children? ☐Yes ☐No How Many?_______
How was the pregnancy and birth?
____
____
____

How was your pregnancy and birth for your mother and you?
____
____

Health

Allergies

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

Health concerns

List in order of importance

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

Childhood diseases

- ☐ German measles
- ☐ Strep throat
- ☐ Measles
- ☐ Mono
- ☐ Rheumatic fever
- ☐ Chicken pox
- ☐ Mumps
- ☐ Other_____________

Life Goals

Goals

What are your spiritual, emotional and/or health goals?
____
____
____
____
____
____
____
____
____
____

Satisfaction

Please indicate your level of satisfaction with the following areas in your life: (1 is low and 10 is highest)

Physical / Environment____
Fun & Recreation___
Romance / Significant Other ___
Friends / Family___
Health____
Money___
Career ___
Personal Growth___

Marilene Richardson, Herbalist
marilene@songcroft.com
PO BOX 1137, Monroe, WA. 98272 ◆ 425-770-1700

BODY TEMPLE WELLNESS

Wellness Coaching

Name:____ Date:____________________________________

Dietary Habits:

Please list below typical foods you consume on a regular basis
Do you have a regular routine around eating? yes___ no___
Breakfast:____
Lunch:____
Dinner:____
Snacks:____
Fluids: ____
Any food cravings - Please list ____
How is your appetite? None___ Weak___ Normal___ Strong___ Irregular___
How does food affect you? Satisfied/Energized___ Unsatisfied/still hungry___ Fatigued/Sleepy___
Is your thirst: Extreme___ Changeable___ No thirst___ Dry Mouth___
Which tastes do you prefer? Sweet___ Sour___ Salty___ Pungent___ Bitter___ Astringent___
Please describe if you are following a special diet ____
____
How many glasses of water do you consume each week? ____
How often do you eat breakfast each week? ____

Daily Routines

	Time	Routine (how often)	Activity	Variation	Spiritual Practice	Exercise
Morning						
Mid-morning						
Lunch						
Mid-afternoon						
Evening						
Late-Evening						
Sleep Patterns						

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Body Temple Wellness

Wellness Coaching

Name:______________________________________ Date:__________________________________

Symptoms

Rate the following symptoms based upon your typical health profile for the last 30 days. Use the following "Point Scale":

0= **Never or almost never** have the symptoms
1= **Occasionally** have symptom, effect is **NOT severe**
2= **Occasionally** have symptom, effect is **severe**
3= **Frequently** have symptom, effect is **NOT severe**
4= **Frequently** have symptom, effect is **severe**

Be sure to add the points up for each individual group of symptoms. At the end of the questionnaire, don't forget to tally the "GRAND TOTAL" of all of the symptom groups.

HEAD/NEUROLOGIC	**0**	**1**	**2**	**3**	**4**
Headache					
Faintness /Dizziness/Vertigo					
Epilepsy/Seizures/Convulsions					
Problems with Speech/Slurred Speech					
Other					
				Total	

EYES	**0**	**1**	**2**	**3**	**4**
Watery/ Itchy eyes					
Floaters					
Swelling					
Reddened or Sticky Eyelids					
Discharge					
Blurred Vision					
Eye Pain					
Dry Eyes					
Poor Night Vision					
Double Vision or Tunnel Vision					
Contact Lenses/Corrective Lenses					
Other					
				Total	

EARS	**0**	**1**	**2**	**3**	**4**
Ear Infections					
Drainage from Ears					
Itchy Ears 1					
Ringing in Ears					
Earaches/Pain					
Hearing Loss/Problems					
Other					
				Total	

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Name:______________________________ Date:______________________________

NOSE	0	1	2	3	4
Nasal Congestion/Post Nasal Drip					
Frequent Infections					
Sneezing Attacks					
Bleeding					
Other					
					Total

MOUTH/THROAT	0	1	2	3	4
Canker or Cold Sores					
Root Canals/Amalgams/Implants/Decay					
Bleeding Gums/Gum Problems Hoarseness/Voice Changes					
Frequent Sore Throat					
Hoarseness/Voice Changes					
Other					
					Total

SKIN	0	1	2	3	4
Eczema /Dry Skin/Itching					
Rashes/Sores hives					
Acne/ Rosacea					
Hair Loss/Dryness or Changes					
Nail Dryness or Changes					
Hot Flashes/ Flushing					
Excessive Sweating					
Dark Circles Under Eyes					
Easy Bruising /Jaundice					
Other					
					Total

RESPIRATORY	0	1	2	3	4
Chronic Cough					
Asthma/Wheezing					
Bronchitis/Pneumonia					
Difficulty breathing /Shortness of breath					
Other					
					Total

CARDIOVASCULAR	0	1	2	3	4
Palpitations/Irregular Heartbeat/Arrythmias					
Chest Pain					
Heart Murmur					
Heart Attack (age:)					
Stroke (age:)					
Swelling of Hands/Feet/Legs/ Fluid retention					
Blood Clots in lungs or legs / Varicose Veins					
Pacemaker					
Other					**Total**

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Name:________________________________ Date:________________________________

GASTROINTESTINAL	0	1	2	3	4
Nausea/Vomiting					
Difficulty or Pain with Swallowing					
Diarrhea					
Constipation					
Bloating/Gas					
Indigestion/Heartburn/Reflux					
Pain or cramping with Digestion					
Loss/Excess Appetite					
Anal Discomfort					
Hemorrhoids					
Blood, Mucus or undigested food in Stool					
Black Tarry or “coffee ground” Stools					
Gallbladder or Liver Disease					
Hepatitis- Type:					
Diverticulitis/Colitis/Crohn’s					
Ulcer					
Other					
				Total	

SYMPTOMS					
MUSCULOSKELETAL	**0**	**1**	**2**	**3**	**4**
Joints: Pain/Aches/Stiffness					
Limitation of Movement					
Muscles: Pain/Aches/Spasm/Strain					
Weakness					
Back Problems					
Osteoporosis/Osteopenia					
Broken Bones					
Trauma/Swelling					
Other					
				Total	

ENDOCRINE	0	1	2	3	4
Thyroid Disease/Goiter					
Cold/Heat Intolerance					
Cold Hands and Feet Diabetes					
Diabetes					
Sweats/Night Sweats/Excessive Thirst night sweats					
Hormone Therapy					
Other					
				Total	

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Name:______________________________ Date:______________________________

ALLERGY/IMMUNITY	0	1	2	3	4
Hay Fever/Asthma/Eczema					
Drug Allergies					
Food Allergies					
Environmental/Animal Allergies					
Autoimmune Disease					
Cancer/Chemotherapy					
HIV/AIDS					
Other					
				Total	

BLOOD/LYMPHATIC	0	1	2	3	4
Anemia					
Bleeding Tendencies					
Blood Transfusions					
Swollen Lymph Nodes					
Blood/ Lymph Disease or Cancer					
Other					
				Total	

ENERGY/ACTIVITY	0	1	2	3	4
Fatigue					
Sluggishness					
Apathy					
Lethargy					
Hyperactivity					
Restlessness					
Other					
				Total	

PSYCHOLOGICAL/EMOTIONS	0	1	2	3	4
Anxiety/Fear/Nervousness/Panic Attacks					
Depression/Sadness					
Difficulty in Comprehension/Concentration/Making Decisions					
Anger/Irritability/Aggressiveness					
Mood Swings/Changes					
Phobias					
Alcohol/Chemical Dependency					
Other					
				Total	

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Name:______________________________ Date:______________________________

WEIGHT	0	1	2	3	4
Overweight/Underweight difficulty losing weight					
Food cravings					
Eating Disorders					
Binge eating/drinking					
Difficulty gaining weight					
Other					
				Total	

STRESS	0	1	2	3	4
What is most stressful in your life?					

IMMUNIZATION HISTORY	DATE	BOOSTERS
Tetanus-Diphtheria (Tdap)		
Measles-Mumps-Rubella (MMR)		
Varicella		
Hepatitis A		
Hepatitis B		
Flu Shot		
Other		

Please include any other pertinent information about your personal history that was not covered in this questionnaire. Use the back if necessary.

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Name:________________________________ Date:________________________________

Physical Quality Assessment

Please rate whether the following physical qualities apply to you.

	QUALITY	Doesn't Apply	Applies Somewhat	Applies
1.	My lifelong tendency has been to be thin and lanky			
2.	I find having a routine in life to be challenging			
3.	My skin tends to be rough and dry, even if I don't live in a dry, arid climate (but especially if I do)			
4.	My joints are fairly prominent			
5.	My teeth are protruded and/or crooked			
6.	My hair is kinky, curly and tends to be dry or frizzy			
7.	It is usually easy for me to lose weight and I usually have difficulty gaining weight			
8.	Usually in my life I enjoy hot weather			
9.	I tend to dislike wind			
10	I tend to dislike dry			
11	I have a medium build with medium bone structure			
12	I enjoy competitive activities and enjoy physical or intellectual challenges			
13	My teeth are medium-sized and/or a little yellow (stained doesn't count)			
14	I have fair skin which easily sunburns			
15	I have a lot of moles or freckles			
16	I am or am becoming bald, I have grayed early, or I have thin or fine hair			
17	Chili peppers, tomatoes and spicy food in general tends to cause me digestive distress, including heartburn or stomachache or loose stools, (even if I really enjoy the taste and am attracted to these things)			
18	I prefer a cool climate to a warm one			
19	I dislike heat, especially humid heat and feel easily fatigued by it			
20	I have a sharp, intelligent, aggressive mind			
21	I have a sturdy constitution with a large bone structure			
22	I have had a lifelong tendency to always be at least a little overweight			
23	My teeth are naturally large, straight and white			
24	My hair is a thick and lustrous			
25	My eyes are large and luxurious			
26	If given the opportunity, I can easily sleep deeply for 8-10 hours per night			
27	I gain weight easily and have difficulty losing weight			
28	I tend to have excess mucous			
29	I tolerate most climates well but usually in my life I have preferred hot, dry weather			
30	My energy and stamina are consistent. When I have a lot to do I do it at a pace that I can maintain for a long time			

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Food History

What was your childhood food like?

What were your ancestral foods?

Current Medical Care

Are you currently under medical care?

Who are your healthcare providers?
(Please all providers you are seeing (i.e. naturopaths/md physicians, massage therapists, acupuncturists, other.)

Name	Location	Reason for visits?

Please list all protocol, medications, supplements and herbs you are currently taking. Include dosages.

Thank you for completing this questionnaire. Please print it out and bring it with you to your appointment.

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