REGISTRATION DATA

Name: _____ Age: _____ Gender: _____
Birth date: _____ Marital status: _____ # of Children: _____
Permanent address: _____
Contact #: _____ Email address: _____
Language spoken: _____ Occupation: _____
Religion faith: _____ Passport #/National ID: _____
Notify in case of emergency Name: _____ Relation: _____
Contact numbers: _____

PROGRAM REGISTRATION:

_____ Medical Consult
_____ Shared Medical Appointment

_____ 10 Day Intensive Lifestyle Medicine Program

_____ 4 Day Detox and Cleansing Program

Session Date: _____ Is this your first time with us? YES _____ NO _____

MEDICAL HISTORY

Check (/) if you have ever been told by a physician that you have any of the following:

____ Angina (yr?)
____ Gallbladder disease
____ Hearth attack (yr?)
____ Angioplasty (yr?)
____ Bypass (yr?)
____ Heart failure (yr?)
____ Blood clotting problem
____ Abnormal ECG (yr?)
____ Irregular heart beats

____ Stroke (yr?)
____ High blood pressure
____ High cholesterol
____ High triglycerides
____ Diabetes
____ Ulcer
____ Thyroid problem
____ Osteoporosis
____ Rheumatoid arthritis
____ Other condition (Please specify)
_____

____ Osteoarthritis
____ Gout
____ Kidney disease
____ Overweight
____ Bronchitis/Emphysema
____ Constipation
____ Diverticulosis/Bowel pockets
____ Irritable bowel syndrome
____ Cancer (type?)

List of Medications, Herbs and Supplements you are taking: I take None _____

Generic/Brand Name	Dose	Purpose

(Please use the space if needed for listing)
Kindly fill in this form diligently as this will serve as basis of our Lifestyle Evaluation

Any history of trauma/accident/surgery (please specify): _____

Any Allergy to food/medicine/herbs (please specify): _____

Family History of Heart disease, Diabetes, Hypertension _____

(Please email medical report, investigations or blood works available)

LIFESTYLE BACKGROUND

Rest and Stress

____ Evening is biggest meal
____ Eat little or no breakfast
____ 6 hours or less sleep/night
____ Sleep restlessly
____ Suffer insomnia
____ Hrs/Week of work
____ Very few vacations
____ Feel under pressure
____ Eat too fast
____ Easily emotionally upset
____ Feel muscular tension
____ Eat between meals
____ Feel fearful and depressed
____ Anxiety, worry and tension

Please Fill in the number of servings you consume weekly (Pls don't leave blank)

____ Meat of shellfish
____ Chicken/Turkey
____ Meat
____ Whole milk or 2%
____ Cheese
____ Butter or cream
____ Sour cream
____ Ice cream/Ice milk
____ Yogurt
____ Liver/Organ meats
____ Sausage/Hotdogs
____ Eggs
____ Fried foods
____ Salty Snacks

____ Salad dressings
____ Mayonnaise
____ Margarine
____ Gravies
____ Soymeat/Gluten
____ Soymilk
____ Water
____ Alcohol
____ Coffee/Tea/Chocolates
____ Soft drinks/Bottled juices
____ Candy or sugar
____ Sugary desserts
____ Honey/Syrups/Jelly
____ Crackers/Cookies/Biscuits

Exercise (beyond everyday occupation)

____ None
____ Mild (2-3 days/week
____ Moderate 3-5 days/week
____ Vigorous 4-6 days/week

Breathing

____ Non-smoker
____ Ex-smoker (yr?___)
____ Smoker (yr? ____ / # of sticks/day? ____ / How often tried to quit? ____
____ Live with smoker

Food Diary

____ Breakfast time
____ Lunch time
____ Snack frequency
____ Sweets frequency

Usual Menu: _____
Usual Menu: _____
Type: _____
Type: _____

VITAL SIGNS/ANTHROPOMETRICS

Blood Pressure:	_____	Weight:	_____
Pulse Rate:	_____	Height:	_____
Respiratory Rate:	_____	BMI:	_____
Temperature:	_____	Waist line:	_____

_____

Signature over printed name

I voluntarily subjected myself for evaluation with and understood the process I have to take. With this, I hereby hold the center free of any legal liabilities as I am duly informed of what to expect with regards to possible outcome.

DATE	PROBLEM LIST	RECOMMENDATION	