



*Complete Wellness Clinic*

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**KIM VIVIAN BSc, ND**



**total health, naturally...**

Welcome! The information package provided below will help you to prepare for your first visit. Please read and fill out the information requested.

Your first visit will typically be 1 hour. During this time a health assessment will be done, followed by a Bowen treatment.

Please bring the following to your first visit:

- t-shirt and shorts (preferably with elastic band or pull string)
- completed forms provided below

I look forward to your first visit and to begin working together to address your health concerns. If you have any questions regarding the procedures described above or otherwise, please feel free to call me.

Sincerely,

*Kim Vivian BSc, ND*



Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

When did you last visit an optometrist? \_\_\_\_\_

Who is your regular optometrist? \_\_\_\_\_

Are you under the care of any specialists? Yes/No \_\_\_\_\_  
(explain)

Are you receiving other health care? Yes/No: \_\_\_\_\_  
(explain)

Please list your major health concerns in order of importance

COMPLAINT	SINCE	POSSIBLE CAUSE(S)

Do you have access to a car? Yes/No

What medications/supplements are you currently taking (prescription/over-the-counter/supplements/vitamins, etc)?

Medications/Supplements	Since	Daily Dose	Side effects you have experienced?

List all surgeries you have had:

Procedure	Year	Complications?

List all major injuries you have sustained:

Injury	Year	Long Term Effects

Which of the following conditions have you had? (Check all that apply)

- Abscesses
- Diabetes
- High Blood Pressure
- Malaria
- Prostatitis
- Thyroid Disease

- Sunstroke
- InfluenzaPeritonitis
- Worms
- PID
- Somisotos
- Alcoholism
- Emphysema
- Allergies
- Epilepsy
- Kidney Disease
- Mumps
- Skin Disease
- Venereal Warts
- Depression
- Pleurisy
- Stroke
- Amnesia
- Gallstones
- Leukemia
- Pneumonia
- Syphilis
- Arthritis
- Gonorrhea
- Asthma
- Herpes Genitalia
- Parasites
- Strep Throat
- Whooping Cough
- Gout
- Measles
- Rheumatic Fever
- Tonsillitis
- Cancer
- Hey Fever
- Miscarriage
- Rubella
- Tuberculosis
- Chicken Pox
- Heart Disease
- Mononucleosis
- Sexual Abuse
- Typhoid
- Cold Sores
- Hepatitis
- Yellow Fever

**Which of the following do you currently use? (amount, how often, how much, how long)**

<b>SUBSTANCE</b>	<b>Amount Used</b>	<b>How often taken</b>	<b>How long taken</b>
Alcohol			
Hormones			
Cortisone			
Sedatives			
Recreational Drugs			
Tobacco			
Coffee			
Laxatives			
Antacids			

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at work, home or traveling? Yes/No

**Which of the following ailments, or any others, have affected your blood parents, grandparents or siblings?**

- Alcoholism
- Depression
- Gallstones
- Hepatitis
- Pneumonia
- Thyroid Disease
- Allergies
- Diabetes
- Glaucoma
- Kidney Disease

- Hay Fever
- Multiple Sclerosis
- Skin Disease
- Asthma
- Cancer
- Emphysema
- Heart Disease
- Mononucleosis
- Strep Throat
- Chronic

- Rheumatic Fever
- Tuberculosis
- Arthritis
- Easy Bleeding
- Gout
- Mental Illness
- Sickle Cell
- Venereal Disease

- Epilepsy
- High Blood
- Osteoporosis
- Stroke
- Bronchitis
- Pressure
- Eczema

Any other medical conditions:

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The general state of your health is in your opinion \_\_\_\_\_ Excellent  
 \_\_\_\_\_ Good  
 \_\_\_\_\_ Average  
 \_\_\_\_\_ Fair  
 \_\_\_\_\_ Poor

On average, describe your energy level (10 = highest & 1= lowest) \_\_\_\_\_  
 When during the day is energy the best? \_\_\_\_\_ and the worst \_\_\_\_\_

Do you exercise? Yes No      What forms? \_\_\_\_\_  
 How often? \_\_\_\_\_

What are you interests or hobbies?

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How many meals do you generally eat each day? \_\_\_\_\_  
 Who cooks and prepares your food? \_\_\_\_\_  
 How long do you take to eat an average meal? \_\_\_\_\_  
 What are you doing when eating? (ie. TV, etc.) \_\_\_\_\_

List any foods you exclude from your diet: \_\_\_\_\_

Why are these foods excluded?

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List any of the foods that you crave (eg. chocolate, salty, sour, breads, rich/fatty or spicy):

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Have you had a bad reaction to any foods?

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Are you satisfied with your diet as it is now? Yes/No  
Are you satisfied with your lifestyle as it is now? Yes/No

Do you tend to be thirsty compared to others around you?: Yes/No  
How many glasses of WATER do you drink each day?: \_\_\_\_\_

Do you prefer beverages: Hot      Cold      Room Temperature

**CIRCLE THE MOST APPROPRIATE DESCRIPTION OF YOUR DIGESTION IN GENERAL:**

Frequency of Bowel Movements in 24 hour period:  
 once       twice       three times       less than once

Color of Bowel Movements:  
 black               dark brown       brown  
 yellow               green

Generally my stool:  
 floats but flushes       floats and is difficult to flush       sinks

I notice grease or fat in my stools:	YES	NO
I experience pain with my bowel movements:	YES	NO
I experience blood in my stools:	YES	NO
I must strain to make a bowel movement:	YES	NO

The odor of my bowel movements is:  
 odorless       mild odor       strong odor

The form of my bowel movement is:  
 hard pellets       thin ribbons       watery       Large single soft

Have you had any adverse effects from a vaccination? Yes/No  
If Yes, which one(s)? \_\_\_\_\_

Have you had any flu shots? Yes/No  
If yes, any adverse effects? \_\_\_\_\_

Please list the most significant, stressful, events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (yes/no)

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_  
3. \_\_\_\_\_ Date: \_\_\_\_\_  
4. \_\_\_\_\_ Date: \_\_\_\_\_  
5. \_\_\_\_\_ Date: \_\_\_\_\_

If you have access to any of the following please circle the appropriate equipment:

- Juicer       Crock Pot       Blender       Coffee Grinder

How much time could you see yourself learning to cook/prepare new foods?

None \_\_\_\_\_      A little \_\_\_\_\_      As much as necessary \_\_\_\_\_

Would you be interested in attending extra workshops to learn valuable life skills about your health?    Yes \_\_\_\_\_      No \_\_\_\_\_

Is there anything else I need to know about you personally, about your health condition, or about circumstances relating to you condition?

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