New Client Questionnaire

Today's Date:

Last Name:	First Name:	Male ☐ Female ☐	Birth Date:	Age:

Address:	Apt. #:	City:	State:	Zip Code:

Home Phone:	Cell Phone:	Email:

Marital Status:	Occupation:	Employer:

How did you hear about Prolean Wellness?

Weight:	Height:	When were you most satisfied with your appearance?

Do you currently exercise? If **yes,** what are you doing?

If you're not exercising, what are your barriers?

What is your current level of stress? (**scale of 1-5, 5 being highest**).	If your stress level is high, why?

How would you rate your sleep? (Check one) Excellent ☐ Average ☐ Poor ☐	How many hours per day do you sleep?

Do you have a problem falling asleep?	Do you have a problem staying asleep?

Describe your energy levels in the morning: (**scale of 1-10)**	Afternoon:	Evening:

Have you tried to lose weight before? If so, what were the results?	What have been your barriers to success?

How many times per day do you eat, including snacks?	If you snack, what are your typical snacks?
Do you typically eat breakfast?	If so, what do you eat?
Do you typically eat lunch?	If so, what do you eat?
Do you typically eat dinner?	If so, what do you eat?
Do you typically eat out?	If so, how many times during the week?
Do you typically consume alcohol of some type? Yes ☐ No ☐ Frequency: Quantity:	Do you use recreational drugs? (e.g., marijuana, cocaine, etc.) Yes ☐ No ☐ Previously ☐ If yes, number of years: Year you quit:
Do you use caffeinated products? (coffee, tea, soda, etc.) Yes ☐ No ☐ Frequency: Quantity:	Who is your primary care physician? Address: Phone number:
Do you use tobacco? Yes ☐ No ☐ Frequency: Quantity:	How much water do you drink on a daily basis?

Medical Conditions/Diseases (Please check all that apply)

☐ Heart Disease (ex. Congestive Heart Failure)
☐ High Cholesterol or Lipids (ex. Hyperlipidemia)
☐ High Blood Pressure (ex. Hypertension)
☐ Lung Condition (ex. Asthma, Emphysema, COPD, Glaucoma, etc.)
☐ Ulcers (Stomach, Esophagus)
☐ Diabetes
☐ Blood Clotting Problems
☐ Arthritis or Joint Problems
☐ Thyroid Disease
☐ Headaches/Migraines
☐ Hormone-related Issues
☐ Cancer
☐ Depression
☐ Epilepsy
☐ Eye Disease

☐ Kidney Disease
☐ None
☐ Other (Please list):

Current Prescription Medications (Please list):

☐ None

Medication Name:	Strength:	Date Started:	Times Per Day:
Medication Name:	Strength:	Date Started:	Times Per Day:
Medication Name:	Strength:	Date Started:	Times Per Day:
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Allergies (Please list):

☐ None

Allergen:	Type of Reaction:
Allergen:	Type of Reaction:
Allergen:	Type of Reaction:
Allergen:	Type of Reaction:

Over the Counter Medications (e.g. aspirin, Tylenol, Aleve, Ibuprofen, vitamins, herbals, hormones, etc.) Please list:

☐ None

Kidney or liver conditions?	Do you currently take supplements? Please list:

Have you had any of the following tests performed? Check all that apply and list date:

Mammography	☐ Yes	☐ No	Date:
PAP Smear	☐ Yes	☐ No	Date:
PSA (males)	☐ Yes	☐ No	Date:

Surgical History (e.g., hernia, appendectomy, hysterectomy, etc.)

☐ None

How often do you have a bowel movement?	How many times do you estimate that you have been on antibiotics? (Ex., 10 times, 2x per year)

Family History

Father- Age:	Significant Health Problems:	Age Deceased:
Cause:		
Mother- Age:	Significant Health Problems:	Age Deceased:
Cause:		
Siblings- Age:	Significant Health Problems:	Age Deceased:
Cause:		
Children- Age:	Significant Health Problems:	Age Deceased:
Cause:		

Check any other family health issues and identify the family member:

☐ High Blood Pressure
☐ Heart Disease
☐ Kidney Disease
☐ Cancer
☐ Diabetes
☐ Gastrointestinal
☐ Bleeding Problems
☐ Other

Do you have medical concerns? Please list:

What do you see happening to you if these concerns are left **unresolved**?

What would you like to see happen to your life now? (Why are you here?)

How important is it to you to resolve your health concerns? (**scale of 1-10**)

How willing are you to make lifestyle changes? (**scale of 1-10**)

How coachable are you? (**scale of 1-10**)

Do you have any interest in hormone balance and correction? ___ Yes ____ No

Do you have any interest in facial rejuvenation (with Botox, Dysport and fillers like Juvederm? ___ Yes ___ No

We offer Stem Cell Therapy for

- Joint problems (proven to help rebuild cartilage)
- Auto-immune disorders such as fibromyalgia, psoriatic arthritis, Ulcerative Colitis, IBS, Lupus, etc.
- Arthritis
- Heart problems
- Kidney Function
- And multiple other health issues that used to require surgery or heavy medication

Do you have any interest in hearing more about these treatments for you or a loved one? ___ Yes ___ No

Patient Signature:
Date: