**Welcome and congratulations for taking this step towards wellness. Before I continue, I’d like to remind you - *a tapestry is stitched one thread at a time.* Be patient with yourself and create your masterpiece one step at a time. How you feel today has everything to do with yesterday's patterns - pattern of thinking, exercise, habits, diet, etc. You must change the way you live today if you want different results than what yesterday’s choices brought you.**

**I’m here to help you *discover how WELL your body is designed to feel.***

**As a Holistic Health Practitioner, I consider the WHOLE you when creating lifestyle changes that will contribute to your wellness journey. With this approach to Restoring Wellness, we won‘t be looking at your concerns as ‘separate’ from the whole picture but part of the collective whole. Asthma, for example, is not just a lung issue. Weight retention is not just poor nutrition or laziness. Arthritis is not just a bone problem and PMS isn't just part of being female. Everything has a greater cause - a larger imbalance - and I'm here to help you translate what your body has been telling you through symptoms.**

**Working Together**

**Initial Health Assessment Date of appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**During our first appointment, we will review your Health Questionnaire while I get to know you a little more. We will consider how foods currently affect you, how stress impacts you, and what you’re currently doing from day to day. We’ll discuss the potential under or over-functioning of certain body systems and how Whole-Life changes can help you recover.**

**Within one week of your initial appointment, you’ll receive an email with your Personalized Evaluation, which may include recommendations for nutrition, supplements, mind-body practices, affirmations, resources, etc. to support your goals as discussed in our initial appointment.**

**Coaching Calls Date of 2nd call: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date of 3rd call: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Over the next month, we will have two, 30-minute coaching calls to help tailor your progress. These calls are meant to hold you accountable as well as modify our approach wherever needed. Healing is quite like an onion with its layers. Sometimes what once worked for you will all-of-a-sudden work less effectively because you have reached a new layer of healing. Whether we modify your dietary lifestyle, incorporate some life coaching techniques for time management or work with your primary care practitioner in adjusting your current medications, our calls evolve to your individual needs and circumstances.**

**Investment**

**The value of this 3-part series of Restoring Wellness is $225, which you can** [pay here,](https://www.paypal.com/paypalme/stephanieaustinhhp/225) and is due when we schedule our first call. T**here is immeasurable value in learning to support the innate self-healing ability of YOUR body, in balance. After our initial 3-part series, a monthly coaching membership with two calls per month is recommended to continue the evolution of your Restoring Wellness journey. For some, that looks like nutrition, coached cleanses, or supplements – for others, mind-body yoga, EFT, or astrology mediation. It evolves, as you do. The cost for the coaching calls is discounted according to membership length. Two (2) 30 to 45-minute calls is $75 paid monthly (reg. $40 each) or only $57/mo when prepaid for three months ($171). Calls do not accumulate and must be used each month as part of your commitment to your wellness journey.**

HEALTH QUESTIONNAIRE

Please be detailed. Once completed, save and email to [stephanie@wellnessbymothernature.com](mailto:stephanie@wellnessbymothernature.com). Alternatively, [click here](http://www.wellnessbymothernature.com/hqf0rm2020.html) to download a version of this questionnaire that you can print, complete, scan and email (or mail) instead.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE: \_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_ PHONE(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEIGHT: \_\_\_\_\_\_\_\_ft\_\_\_\_\_\_\_\_in DOB (DD/MM/YYYY):                      AGE:

WEIGHT:            today       highest       when?       lowest       when?

ARE YOU WILLING TO INVITE CHANGE INTO YOUR LIFESTYLE SO AS TO IMRPOVE YOUR MENTAL, PHYSICAL, EMOTIONAL, SPIRITUAL AND ENVIRONMENTAL HEALTH?

ARE YOU PREPARED TO CHANGE THE WAY YOU THINK, FIRSTLY?            FOLLOWED CLOSELY BY THE WAY YOU FEEL?            BECAUSE ONLY THROUGH CHANGING YESTERDAY - WITH A WILLINGNESS TO ENTER THE UNKNOWN, NEW WAYS OF BEING, CAN YOU CHANGE TOMORROW.

PRIMARY CONCERN FOR THIS CONSULTATION:

WHAT THERAPIES HAVE YOU USED FOR PRIMARY CONCERN (MEDICAL DOCTOR, MEDICAL INTUITIVE, CHIROPRACTIC, MASSAGE, REIKI, PHYSICAL THERAPY, ETC. BOTH COMPLIMENTARY AND TRADITIONAL)?

WHEN DID YOU FIRST NOTICE SIGNS OR SYMPTOMS? (YEAR, WEATHER, AFTER LIFE CHANGES, ETC)

WHAT MAKES SYMPTOMS WORSE? (IE. WEATHER, ACTIVITIES, RELAXATION, SITTING, EXERCISE, STRESS, ETC)

WHAT MAKES SYMPTOMS BETTER? (IE. WEATHER, ACTIVITIES, RELAXATION, SITTING, EXERCISE, STRESS, ETC)

MAJOR LIFE CHANGES IN THE PAST YEAR (NEW JOB, BABY, LOSS, RETIREMENT, MOVE, DIVORCE, ETC):

MAJOR LIFE CHANGES AROUND THE ONSET OF YOUR CONCERN:

DO YOU HAVE ANY SPECIAL NEEDS TO BE CONSIDERED DURING OUR CONSULTATION (DIFFICULTY HEARING, LANGUAGE, DYSLEXIA, ATTENTION, ETC):

OVERALL HEALTH:            POOR           FAIR            GOOD            EXCELLENT

HOW WOULD YOU DESCRIBE YOUR EMOTIONAL WELL-BEING:

           BALANCED/GENERALLY CONTENT            FLUCTUATES EASILY            DEPRESSED

           THOUGHTS OF HOPELESSNESS            UNABLE TO PINPOINT                           OTHER

STRESS LEVEL:            MILD            MODERATE            SEVERE

WHAT ARE THE CAUSES OF YOUR STRESS:

HOW DOES STRESS AFFECT YOU (CRY, ANGER, ANXIETY, UPSET STOMACH, LETHARGY, ETC):

DO YOU USE TOBACCO?            IF YES, HOW OFTEN?

DO YOU USE ALCOHOL?            IF YES, WHAT KIND AND HOW OFTEN?

DO YOU USE CAFFEINE?            IF YES, WHAT KIND AND HOW OFTEN?

DO YOU USE OTHER DRUGS?            IF YES, WHAT KIND AND HOW OFTEN?

DESCRIBE THE MOVEMENT IN YOUR LIFE AND HOW OFTEN FOR EACH TYPE LISTED

(YOGA, HOUSEKEEPING, WALKING, GYM, HIKING, ETC):                                              |

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LIST ANY MEDICAL CONDITION FOR WHICH YOU’VE BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER (DIABETES I OR II, HIGH BLOOD PRESSURE, LACTOSE INTOLERANT, ALLERIES TO MOLD, AUTOIMMUNE, ETC)

CONDITION WHEN TESTS TAKEN/RESULTS

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LIST ANY SURGERIES, INJURIES, AND/OR HOSPITALIZATIONS (CHILDBIRTH, ORGANS REMOVED, BROKEN BONES, ETC)

CONDITION WHEN TESTS TAKEN/RESULTS

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LIST ANY KNOWN OR PRESUMED ALLERGIES (ENVIRONMENTAL AND FOOD RELATED)

OTHER CONCERNS OR EXTRA SPACE

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| SYMPTOM HISTORY - CHECK THE FOLLOWING SYMPTOMS WITH AN ‘X’ THAT APPLY TO YOU CURRENTLY AND/OR PAST | | | | | | | |
| **MUSCULOSKELETAL** | | | | | | | |
| HEADACHES |  | JOINT STIFFNESS / SWELLING |  | SPASMS/ CRAMPS |  | BROKEN / FRACTURED BONES |  |
| STRAINS SPRAINS |  | BACK / HIP PAIN |  | SHOULDER / NECK / ARM / HAND PAIN |  | LEG / FOOT PAIN |  |
| CHEST/RIBS /ABDOMINAL PAIN |  | PROBLEMS WALKING |  | JAW PAIN / TMJ |  |  | OTHER? |
| **SKIN** | | | | | | | |
| RASHES |  | ALLERGIES |  | ATHLETE’S FOOT |  | WARTS |  |
| SWELLING / REDNESS |  | ACNE |  | ITCHING |  |  | OTHER? |
| **REPRODUCTIVE** | | | | | | | |
| CURRENTLY PREGNANT |  | PREVIOUS PREGNANCIES |  | PMS |  | MENOPAUSE |  |
| PELVIC INFLAMMATORY DISEASE |  | ENDOMETRIOSIS |  | FERTILITY CONCERNS |  | PROSTATE CONCERNS |  |
| IMPOTENCY |  | GENITAL ITCHING / DISCHARGE |  | STD’S |  |  | OTHER? |
| **CIRCULATORY AND RESPIRATORY** | | | | | | | |
| DIZZINESS |  | SHORTNESS OF BREATH |  | FAINTING |  | COLD HANDS / FEET |  |
| SWOLLEN ANKLES |  | PRESSURE SORES |  | VARICOSE VEINS |  | HEMORRHOIDS |  |
| BLOOD CLOTS |  | FATIGUE |  | STROKE |  | HEART PALPITATIONS |  |
| HEART MURMUR |  | ALLERGIES |  | SINUS PROBLEMS |  |  | OTHER? |
| **DIGESTIVE** | | | | | | | |
| NERVOUS STOMACH |  | INDIGESTION |  | CONSTIPATION |  | DIARRHEA |  |
| INTESTIONAL BLOATING / GAS |  | IRREGULARITY |  | ULCERS |  |  | OTHER? |
| **NERVOUS SYSTEM** | | | | | | | |
| NUMBNESS / TINGLING |  | TWITCHING OF FACE |  | FATIGUE |  | CHRONIC PAIN |  |
| SLEEP DISORDERS |  | PARALYSIS |  | TREMORS |  | HERPES / SHINGLES |  |
| SHARP OR SHOOTING PAINS |  | ANXIETY |  | NAUSEA FROM FEAR |  |  | OTHER? |
| **OTHER** | | | | | | | |
| LOSS OF APPETITE |  | FORGETFULNESS |  | CONFUSION |  | EATING DISORDER |  |
| DIFFICULTY CONCENTRATING |  | HEARING IMPAIRED |  | VISUALLY IMPAIRED |  | BURNING UPON URINATION/UTI |  |

LIST ANY HEALTH CONDITIONS OF YOUR MOTHER

LIST ANY HEALTH CONDITIONS OF YOUR FATHER

LIST ANY HEALTH CONDITIONS OF YOUR SIBLINGS

WHAT DOES A TYPICAL FEW DAYS OF EATING LOOKS LIKE FOR YOU? DO NOT USE THIS JOURNAL AS A TIME TO RETHINK YOUR CHOICES, JUST INPUT THE REALITY OF WHAT YOU ATE AND DRANK.

DAY 1 FOOD/SNACKS HOW MUCH WATER, HERBAL TEA, OR BROTH?

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HOW DID TODAY’S FOOD CHOICES MAKE YOU FEEL

DAY 2 FOOD/SNACKS HOW MUCH WATER, HERBAL TEA, OR BROTH?

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HOW DID TODAY’S FOOD CHOICES MAKE YOU FEEL

DAY 3 FOOD/SNACKS HOW MUCH WATER, HERBAL TEA, OR BROTH?

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HOW DID TODAY’S FOOD CHOICES MAKE YOU FEEL

USE THE SPACE BELOW TO WRITE ADDITIONAL NOTES, COMMENTS, THOUGHTS, EMOTIONS, ETC. FREE SPACE

Conditions of Consultation

*If you are having an emergency, please contact your local hospital and/or Primary Healthcare Provider.*

The information provided by Stephanie Gibson, Certified Holistic Health Practitioner, Reiki II Healer, and Yoga Teacher, is for educational purposes only and will never act as a diagnosis, cure, or treatment of any disease or health condition; nor does it advise against the use of traditional medicine from a licensed health care provider. The services provided offer to educate about the intrinsic self-healing abilities of a body in balance. Always consult your physician before making dietary and lifestyle changes.

I,                      understand and agree with the following:

* Stephanie Gibson is not a licensed medical doctor, naturopath, mental health practitioner, or registered dietician.
* At no time are her services to be construed as medical diagnosis, treatment, or prescription.
* The general benefits, methods of use, and possible contraindications of the holistic health plan have been explained to me, or I take it upon myself to inquire and research further before starting.
* Stephanie Gibson cannot recommend dosages beyond what is found on a product label.
* I understand that the recommended holistic therapy is not a substitute of medical treatment or medications, and that the practitioner recommends I concurrently work with my Primary Care Provider (PCP) for any condition I (or my child) may have.
* I have informed the consulting practitioner of all known physical and medical conditions, supplements, therapies, and medications, and I will keep the practitioner updated on any changes.
* I give consent for the practitioner to consult with me about my (or my child’s) condition and to devise a holistic health plan for me (or my child).
* I understand that I am receiving the consulting services of the practitioner for a fee of $225 (3-part series) and I am financially responsible for this fee, and any supplements or therapies I choose to add on.
* I agree not to hold the practitioner responsible for any negative outcomes resulting from her services.
* I am over 18 years of age or the legal guardian of the person receiving the consultation.
* I understand my information is provided to aid my consultant in providing a personalized and detailed plan and will only be shared for the specific purposes of providing treatment to me, receiving payment for services rendered to me, and for general administrative operations of the practice.
* I have read the Conditions of Consultation above and agree that I understand the conditions completely; thereby accepting full responsibility for what advice I choose to enact.
* I acknowledge all content received is under copyright of Stephanie Gibson and/or her contributors, and I will not replicate any material for personal use or profit, without express, written permission.
* Occasionally we send out newsletters, announcements, and special occasion cards. If you do not wish to receive these, please initial here      .
* *If completed online, I endorse this as a digital signature.*

**Sign:**                                     Print:                               Date: