

Name _____ Date _____

Address: _____

Email: _____

Best phone number to reach you: _____

Date of Birth: _____ Age: _____ Female / Male

Main Complaints About Your Health That You Want To Work On:

1) _____

2) _____

3) _____

How long have you suffered with these problems? _____

Would you like improvement with any of the following?:

- Digestion: Reflux, Gas, Constipation
- Sleep: Falling asleep or staying asleep
- Sense of Well Being

Rate your current **level of energy** that you have on an average daily basis.

0% = no energy and 100% is full energy: _____%

Any other health complaints: _____

Have you become discouraged or stressed about handling this problem? **Yes or No**

When your problems are at their worst, how do they make you feel? How much older does this make you feel?

How do these this problems interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

Do you know how this problem may have started? _____

Are there any health conditions you are afraid this might turn into?

Diminished Future Abilities, Weight Gain, Heart Disease, Depression, Surgery, Stroke, Cancer, Blindness Other _____

Where do you picture yourself being in the next 3-5 years **if this problem is not taken care of?** Please be specific.

What would be different or better without this problem? Please circle:
Diminished Stress, More Energy, Self Esteem, Confidence, Sleep, Work, Outlook on life, Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list). In other words, why do you want to improve your health? What really matters to you?

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers? Yes or No
Explain?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

- _____ How important is it for you to reach your health goals?
_____ What is your level of commitment to studying each week of this program?
_____ How prepared are you to making the appropriate lifestyle changes that may be necessary in order to achieve your goals?

How important is this problem for you to solve? Is this something you'd spend: (check one)

- _____ \$300 to solve this problem
_____ \$3000 to solve this problem
_____ \$30,000 to solve this problem

Now write down your **two biggest goals** you want to achieve from doing this program and why you want to achieve them.

GOAL #1: _____

Why? _____

GOAL #2: _____

Why?: _____

Consultation Terms

1. I understand that today's consultation is used to determine whether or not I am a candidate for care.
2. I understand that the consultation process does not establish me as a patient under Dr. Shwaluk's care and there is no doctor-patient relationship or obligation.
3. I am aware that after the consultation, I may not be accepted as a patient.
4. I understand that Dr. Shwaluk is not able to and does not accept every case. Dr. Shwaluk's schedule is extremely busy and she strictly limits the number of new patients she accepts so as to ensure a high quality of care.
5. Please fill out all paperwork completely to the best of your knowledge. Do not leave anything blank. If paperwork is not filled out completely Dr. Shwaluk may refuse to do the consultation.
6. It is imperative that you are under the care of a medical doctor or a doctor licensed to prescribe medication. Please list below the name and contact information of that physician.

Name of Physician

Phone number

I have read, understand and accept the terms of the consultation.

Name (please print)

Signature

Date