



*Well of Life Center*  
FOR NATURAL HEALTH

## **New Client Paperwork**

**Please remember to bring this paperwork completed along with any medication you may be on to your New Client Appointment.**

*(If your paperwork is not completed you may be asked to reschedule your appointment)*

**Be sure to have filled out the online questionnaire prior to your appointment time.**

**Please contact our Client Advocate if you have any questions or need additional information.**

Well of Life Center for Natural Health

(610) 346-9080 • [info@welloflifecenter.com](mailto:info@welloflifecenter.com) • 3172 Route 212 PO Box 117, Springtown, PA 18081  
(215) 340-3930 • [doylestown@welloflifecenter.com](mailto:doylestown@welloflifecenter.com) • 201 Farm Lane • Doylestown, PA 18901

**Confidential Health Questionnaire**

Fax: (610) 346-9120  
E-mail: [info@welloflifecenter.com](mailto:info@welloflifecenter.com)

Consultation Date: \_\_\_\_\_  
Consultation Time: \_\_\_\_\_

**\*\* All of your personal information will remain strictly confidential! \*\***

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Name: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_  
Would you like your weight to be different? \_\_\_\_\_ If so, what? \_\_\_\_\_  
Occupation: \_\_\_\_\_ How many hours do you work per week? \_\_\_\_\_  
Relationship Status: \_\_\_\_\_ Children? \_\_\_\_\_  
Blood Type (if known): \_\_\_\_\_  
Referred by: \_\_\_\_\_

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Describe the symptoms you are currently experiencing: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to accomplish/gain from this consultation? \_\_\_\_\_  
\_\_\_\_\_

Do you sleep well? \_\_\_\_\_  
Do wake up during the night? \_\_\_\_\_ If so, what time(s)? \_\_\_\_\_  
What time do you go to bed? \_\_\_\_\_ What time do you generally wake-up? \_\_\_\_\_  
How do you feel when you wake up? \_\_\_\_\_  
Do you drink caffeinated drinks? \_\_\_\_\_ How much & how often? \_\_\_\_\_  
Do you smoke? \_\_\_\_\_ How much & how often? \_\_\_\_\_  
If no, why, how and when did you quit? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ How much & how often? \_\_\_\_\_  
Do you drink soda (diet or regular)? \_\_\_\_\_ How much & how often? \_\_\_\_\_  
What role does exercise play in your life? \_\_\_\_\_  
How much water do you drink per day? \_\_\_\_\_

Are you currently taking any vitamins/minerals/herbs/homeopathic remedies, prescription or non-prescription medications, aspirin, laxatives, diet pills, or any other supplements? Please list all below including name brands and amounts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any known allergies to medications or herbs? Please list all -

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Are you currently under a practitioner's care for a specific health issue? If so, what treatments are you undergoing?

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Please list any surgeries, accidents, injuries or childhood diseases you have had along with the type and date:

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**What are your eating/drinking habits these days?**

Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

What were your eating habits like as a child? (List types of foods) \_\_\_\_\_

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What percentage of your food is home cooked? \_\_\_\_\_

How often do you eat out? \_\_\_\_\_

What are the three worst foods you eat each week? \_\_\_\_\_

What are the three healthiest foods you eat each week? \_\_\_\_\_

Do you crave sugar? \_\_\_\_\_ Do you crave salt? \_\_\_\_\_

Do you feel tired, bloated, and/or gassy after meals? \_\_\_\_\_

Do you experience constipation or diarrhea often? \_\_\_\_\_ When & how often? \_\_\_\_\_

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Do you feel excessively hungry? \_\_\_\_\_ Do you have a poor appetite? \_\_\_\_\_

Please list any known food allergies and/or intolerances:

Within the last two years, have you been tested for any of the following hormones?

- 1) DHEA \_\_\_\_\_
- 2) Cortisol \_\_\_\_\_
- 3) Testosterone \_\_\_\_\_
- 4) Estrogen \_\_\_\_\_
- 5) Progesterone \_\_\_\_\_

Were your hormone levels normal? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

Have you had any previous colon cleansing sessions with a certified colon therapist? \_\_\_\_\_

When? \_\_\_\_\_ How many? \_\_\_\_\_

**Family Health History**

Diabetes? \_\_\_\_\_ Kidney disease? \_\_\_\_\_

Heart Disease? \_\_\_\_\_ Arthritis? \_\_\_\_\_

Asthma? \_\_\_\_\_ Gallbladder disease? \_\_\_\_\_

Cancer? \_\_\_\_\_ Type of cancer? \_\_\_\_\_

Stomach/Intestinal disorders? \_\_\_\_\_ Other: \_\_\_\_\_

Mother: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

Father: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

Maternal Grandmother: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

Paternal Grandmother: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

Maternal Grandfather: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

Paternal Grandfather: Age: \_\_\_\_\_ Died from? \_\_\_\_\_

**WOMEN ONLY:**

Age of your first period: \_\_\_\_\_ Are your periods regular? \_\_\_\_\_

How frequent? \_\_\_\_\_ # of pregnancies \_\_\_\_\_

How many days is your flow? \_\_\_\_\_

Do you experience PMS? \_\_\_\_\_ Is it mild or severe? \_\_\_\_\_

Are you peri-menopausal? \_\_\_\_\_ When did this change first occur? \_\_\_\_\_

Are you menopausal? \_\_\_\_\_ When was your last period? \_\_\_\_\_

List your symptoms of peri/menopause: \_\_\_\_\_

How many children have you delivered and how were they born (vaginally or by cesarean)?

Were there complications associated with these births? \_\_\_\_\_ Please explain: \_\_\_\_\_

Did you receive antibiotics during labor? \_\_\_\_\_

Have you ever had a miscarriage or an abortion? \_\_\_\_\_ How many? \_\_\_\_\_

**Health Check List - please mark with an "x" if it applies. Leave Blank if it does not apply to you.**

<input type="checkbox"/>	Absence of Period	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	Hyperactive	<input type="checkbox"/>	Poor Concentration
<input type="checkbox"/>	Acne	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Poor Memory
<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Adrenal Glands	<input type="checkbox"/>	Cravings	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Prostate
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	Rapid Heartbeat
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Anger	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Reflux
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Digestion	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Reproductive
<input type="checkbox"/>	Apathy	<input type="checkbox"/>	Dizzy Spells	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Respiratory
<input type="checkbox"/>	Appetite	<input type="checkbox"/>	Ear Drainage	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	Restlessness
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Ear Infection	<input type="checkbox"/>	Irregular Pap Tests	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Ear Ringing	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Ring Worm
<input type="checkbox"/>	Atherosclerosis	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	Itchy Ears	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	Itchy or Red Eyes	<input type="checkbox"/>	Sensitive Skin
<input type="checkbox"/>	Bad Breath	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Sensitive Teeth-Nerves
<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	Edema	<input type="checkbox"/>	Kidney Failure	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	Belching	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Kidney Infection	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Bell's Palsy	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Kidney Issues	<input type="checkbox"/>	Sinus
<input type="checkbox"/>	Binge Eating	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Skin Issues
<input type="checkbox"/>	Bites	<input type="checkbox"/>	Excess Sweating	<input type="checkbox"/>	Laryngitis	<input type="checkbox"/>	Sneezing
<input type="checkbox"/>	Bladder	<input type="checkbox"/>	Eyesight	<input type="checkbox"/>	Learning	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Bloating	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Leprosy	<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	Blood Pressure High	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Stomach
<input type="checkbox"/>	Blood Pressure Low	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Liver	<input type="checkbox"/>	Stress
<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Fibrocystic Breasts	<input type="checkbox"/>	Lung Issues	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Boils	<input type="checkbox"/>	Flu	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Stuffy Nose
<input type="checkbox"/>	Bones	<input type="checkbox"/>	Frequent Illness	<input type="checkbox"/>	Lymph Glands	<input type="checkbox"/>	Stuttering
<input type="checkbox"/>	Breathing	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	Menopause	<input type="checkbox"/>	Sty
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Gangrene	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	Swelling of Ankles
<input type="checkbox"/>	Bruises	<input type="checkbox"/>	Gas	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Teething
<input type="checkbox"/>	Burning Urination	<input type="checkbox"/>	Genital Itch/Discharge	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Tennis Elbow
<input type="checkbox"/>	Burns	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	Tonsilitis
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Gums	<input type="checkbox"/>	Mucous	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	Candida	<input type="checkbox"/>	Hair Issues	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	Tunnel Vision
<input type="checkbox"/>	Canker Sores	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Nails	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Urinary Infections
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Vaginitis
<input type="checkbox"/>	Chest Congestion	<input type="checkbox"/>	Heart Issues	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	Vertigo
<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	Water Retention
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Perspiration	<input type="checkbox"/>	Watery Eyes
<input type="checkbox"/>	Circulation	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	Weight - Overweight
<input type="checkbox"/>	Cold-Common	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	Weight - Underweight
<input type="checkbox"/>	Cold-Temperature	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Perspiration	<input type="checkbox"/>	Yeast Infections
<input type="checkbox"/>	Colic	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	PMS		
<input type="checkbox"/>	Colon	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Pneumonia		
<input type="checkbox"/>	Compulsive Eating	<input type="checkbox"/>	Hormones	<input type="checkbox"/>	Polyps		

## **AGREEMENT AND RELEASE OF LIABILITY**

The health and nutritional information you receive from any Well of Life Center Clinician or employee, whether given by phone, in person at your home, in a Well of Life Center office, through lectures, workshops, brochures, emails, or newsletters is not intended to diagnose, prescribe, treat, cure, alleviate, prevent or care for any disease in any way. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include: modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as client results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a clinician or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body and who has experience in treating immune disorders and other health imbalances. Please be aware that you have the right to make your own health decisions based on any information made available to you. **YOU are the driving force in guiding yourself on a path to health!**

### **ACKNOWLEDGEMENT**

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by the clinicians or employees of the Well of Life Center for Natural Health, LLC is to be used for educational purposes only. I also acknowledge that neither Well of Life Center for Natural Health, LLC, Cynthia Hofmann, Tiffany Guerreiro, Anthony Blasco, Victoria Fisher, Felicia Pasquale nor any of the staff members at the Well of Life Center for Natural Health claim to be medical doctors and will not prescribe for or diagnose, treat, prevent, alleviate or cure any disease or condition. Well of Life Center for Natural Health, LLC and its nutritional clinicians have been thoroughly trained and certified.

If I experience any changes in my health or current medications, I will immediately communicate this information to Well of Life Center for Natural Health, LLC. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Well of Life Center for Natural Health, LLC liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Nutrition Response Testing is not a method for "Diagnosing" or "Treating" of any disease including conditions of cancer, AIS, Infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

In consideration of being allowed to participate in programs, modalities, and activities of Well of Life Center for Natural Health, LLC. and to use its facilities in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Well of Life Center for Natural Health, LLC. and its directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery. I do also hereby release all of these mentioned and any others acting upon their behalf from any responsibility or liability from any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Well of Life Center for Natural Health, LLC.,.

I have read and understand the foregoing. Intending to be legally bound, I hereby release the Well of Life Center from any liability, including for negligence, regarding my health matters and my participation in Nutrition Response Testing or any other program. This release applies to all subsequent visits for programs, modalities and activities at the Well of Life Center for Natural Health, LLC.

Client Name (print): \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **CONSULTATION DURATIONS AND FEES**

Initial Consultation (45 minutes) - \$200.00  
Follow-up Report of Finding - no charge  
Follow-up visit with Clinician (15 minutes) - \$50.00  
Additional time with Clinician \$15.00 per additional 5 minutes

We accept Visa, MasterCard, Amex and Discover. Please bring your completed paperwork to your initial consultation. Payment is due upon the completion of your consultation. For more information about Nutrition Response Testing, please visit [www.welloflifecenter.com](http://www.welloflifecenter.com) and navigate to our Nutrition Services page.