MPL Group's GetWellness Center
7601 Sunrise Blvd, Suite #8, Citrus Heights, CA 95610
(916) 721-6566 Office * Getwellnesscenter.com

Physical Coaching * Emotional Health Coaching * Nutritional Counseling * Spiritual Counseling * Financial Counseling

Colon Hydrotherapy * Massage Therapy * Supplement Counseling * Ozone Therapy * Detoxification

Assessment - Intake Form

Name: _____ Date: _____/_____/_____

Address _____City _____ Zip _____

Email Address _____

Cell Phone (_____) _____-_____ Other (_____) _____-_____

Do you have, or have you had any of the following? (Please circle Y ~ Yes or N ~ No):

Smoker Y / N	Pregnant Y / N (#_____)	Contagious Disease Y / N	Goiter Y / N
High/Low Blood Pressure Y / N	Allergies Y / N	Heart Condition Y / N	Skin Disease Y / N
Epilepsy / Seizures Y / N	Thyroid Issues Y / N	Diabetic / T1 – T2 Y / N	Ulcers Y / N
Frequent Headaches Y / N	Migraines Y / N	Varicose Veins Y / N	Acute Colitis Y / N
Cancer Y / N	Nausea Y / N	Memory/Brain Fog Y / N	TB Y / N
Prostate Disease Y / N	Heart Murmurs Y / N	Chest pain Y / N	Acute IBS Y / N
Swelling Ankles Y / N	Hernias Y /N	Cold hands or feet Y / N	Hepatitis Y / N
TMJ Y / N	Dizziness Y / N	Depression Y / N	Diarrhea Y / N
Crohn's Disease Y /N	Ulceration Colitis Y / N	Lung Disease Y / N	Asthma Y / N
AIDS / HIV Y / N	Stroke Y / N	Diverticulitis Y / N	Constipation Y / N
Inflamed Bowel Y / N	Venereal Disease or STD Y / N	Deep Vein Thrombosis Y / N	Anxiety Y / N
Hemorrhoids Y / N	Rectal Bleeding / Fissures Y / N	Immune System Disease Y / N	Enlarged Prostate Y/N
Bruising Y / N	Tissue Disorder Y / N	Hemophilia Disorder Y / N	Sleep Apnea Y / N
MS Y / N	Bacterial or Viral Disorder Y / N	Brain Injury Y / N	Vaccinations Y /N
Chemotherapy Y / N	Statin Drugs Y / N	Silver Amalgam Y / N	

If yes to any of the above, please briefly explain?

_____

Are you currently suffering from any pain related to traumatic experience? (IE.: car accidents, sports injuries, surgeries)
Y / N If yes, briefly explain what and when? _____

Are you currently taking any medications or supplements? (Prescription and/or non-prescription) Y / N

If yes, to the above question please list name(s) of medications / supplements and dose(s):
_____

Are there any upcoming events that will affect you emotionally or financially IE., celebrations? Y / N
_____

Do you have any specific instructions from your doctor regarding condition(s), RX etc.? Y / N If yes, please explain:
_____

Is it okay for us to contact your healthcare provider? Y / N
If yes, please provide information below.
Name: _____Phone number (_____) _____-_____
Address: _____
Email Address _____

Any surgeries in the past 5 years Y / N If yes, please explain: _____

Do you work around toxic materials Y / N If yes, please explain? _____

Have you ever received nutritional counseling before? Y / N If yes, please provide who, what and when? _____
_____

Nutritional Plan: Mixed ___ Vegetarian ___ Sugar Cravings ___ Heavy Meat Eater ___ Dairy Products ___ Other ___

Your top 3 long and/or short-term goals: What would you like to achieve? What are your main goals? Please be specific. Please number 1-3 (1 being most important to you). SMART (Specific- Measurable- Attainable- Realistic- Track-able)
1_____
2_____
3_____

Were you referred by anyone? _____ Relationship _____

Date of Birth ____/_____/_____ Weight _____ Goal Weight _____ Height _____

Date of last menstrual Cycle (if applicable) _____ Consistent Y / N Birth Control Y / N Method _____

Blood Type ____ Bowel movements _____ times per day; circle consistency (smooth, pellets, loose). _____

Social Security #_____-_____-_____ Driver License Number _____ State _____

Individuals with MPL Group, LLC, or MPL Group's GetWellness Center all agents and contractors, are coaches / consultants, not medical doctors; we practice behavior modification, not medicine. We do not treat, diagnose or cure. You are advised to consult with a qualified Medical Doctor. Should you be under a physician's care for any reason we recommend that you seek the advice of your personal physician prior to beginning our program(s). You understand that reaching your personal goals is completely your responsibility. Coaches/Consultants have / will provide you with adequate information to assist you in reaching your goals. You understand that it is imperative, to your success, that you read all provided material and it is up to you to follow the recommended use of supplements for the greatest sustainable results. In addition, we are obligated, by law, (mandatory reporter) to report any suspected abuse. _____
(Initials)
HIPPA Statement: The information herein is private and will not be shared without your written consent or unless obligated by law. You agree to not involve us in litigation and indemnify us against all court actions and understand that we are lay counsel and not lawyers. _____
(Initials)

I attest that the above is true and accurate to the best of my knowledge.

Clients Signature: _____ Date: _____

Print Name: _____