

***Rosen Wellness***  
***Consultation Assessment (Male)***

**General Information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Guardian (if under 18): \_\_\_\_\_

Height: \_\_\_' \_\_\_" Weight: \_\_\_\_\_ lbs. Blood Type \_\_\_\_\_

Emergency contact & phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about Rosen Wellness? \_\_\_\_\_

Major complaint(s) in order of significance to you:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

How do these conditions affect your daily activities? \_\_\_\_\_

Why are you seeking a consultation? If you have any specific health condition, please describe it in detail including the first time you noticed the condition.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical History:**

Prescription Drug Usage – Please check if you use any of the following:

- Antacids, Zantac, Pepcid AC, Rolaids, etc.
- Thyroid
- Chemotherapy
- Relaxants/Sleeping pills
- Radiation
- Antidepressants
- Laxatives
- Aspirin/Acetaminophen
- Ulcer medications
- Cortisone/Anti-Inflammatory
- Antibiotic/Antifungal
- Anti-diabetic/Insulin
- Erectile Dysfunction medications
- Heart medications
- Hormones
- High blood pressure medicine
- Statins/Cholesterol lowering medications

Please list any medications (prescription and/or over the counter) that you are *currently* taking.

Medication:	For what:	Dosage:	Taking for how long:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

List any nutritional supplements and/or herbs you are *currently* taking.

Supplement/Herb	For what:	Dosage:	Taking for how long:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Please list any major surgeries you have had and approximate dates:

Surgery	For what:	Date:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Have you taken antibiotics within the past six months? \_\_\_\_\_

How frequently have you taken antibiotics during your life? \_\_\_\_\_

How many bowel movements do you average per day? \_\_\_\_\_

Describe the condition of your skin (without lotion): Very dry Dry Normal Oily

Please check all that pertain:

Do you have any history of prostate problems or prostate enlargement?  Yes  No

If so, please explain:

When was your last prostate exam? \_\_\_\_\_

What were your most recent PSA results? \_\_\_\_\_ Date\_\_\_\_\_

Does your bladder always feel full?  Yes  No  Sometimes

Do you experience inconsistent pressure or pain during urination?

Yes  No  Sometimes

Do you have difficulty urinating?  Yes  No  Sometimes

Do you have to urinate frequently?  Yes  No  Sometimes

Do you wake up to urinate?  Yes  No  Sometimes

If yes, how many times per night on average? \_\_\_\_\_

Do you have difficulty with erection?  Yes  No  Sometimes

Does ejaculation cause pain?  Yes  No  Sometimes

Do you experience low sex drive?  Yes  No  Sometimes

Do you have premature ejaculation?  Yes  No  Sometimes

Please place an "X" next to all of the following substances that you use and/or consume:

Tap Water

NutraSweet/Sweet n' Low

Coffee

Candy

Tea

"Normal House Cleaning Products

Soft Drinks

(*not "green" products*)

Hair Dyes

"Normal" Cosmetics (*not health food*

Packaged Food

store types)

**Dietary Habits:** Are you vegetarian or vegan? (Circle either if yes)

What do you normally eat for:

Breakfast:

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Lunch: \_\_\_\_\_

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Dinner: \_\_\_\_\_

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Number of snacks during the day: \_\_\_\_\_

Describe your typical snack(s):

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What beverages do you usually drink and how much per day?

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Do you ever buy organic foods?  Never  Sometimes  Usually  Always

What do you buy organic:  Fruits  Vegetables  Meat  Dairy  Boxed  
 Canned  Frozen

How many meals do you eat out at restaurants during a typical week? \_\_\_\_\_

How many are at fast food restaurants? \_\_\_\_\_

Do you crave any of the following?

Sugar  Meat Fat  Chocolate  Fish  Alcohol  
 Desserts  Milk  Bread  Fried foods  
 Other \_\_\_\_\_

Which oils do you use/consume?

Butter  Peanut Oil  Canola  Margarine  Corn Oil  Sun/Safflower  
 Olive Oil  Crisco  Mayonnaise  Coconut Oil  Vegetable Oil  Flaxseed Oil  
 Soybean Oil  Grape Seed Oil  Other \_\_\_\_\_

The dairy products I eat are mostly (circle one):

Full fat  Low fat  Skim  I don't eat dairy products

My intake of artificial sweeteners is:  Frequent  Occasional  Infrequent

Do you smoke cigarettes or use other tobacco products?  Y  N

For the purposes of the following question a drink is considered to be a 12-ounce beer, a four ounce glass of wine, or a shot of hard liquor. On an average day I have:

No drinks  1 drink  2 drinks  3-4 drinks  More than 4 drinks

List any food allergies, restrictions, or sensitivities you are aware of:

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How often do you eat the following foods? (Use the **past three months** as your time frame)

GRAINS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Refined grains: White bread, wheat bread (not whole grain), tortilla, roll, biscuit, muffin, English muffin or bagel							
b. Cooked cereal							
c. Cold cereal							
d. Refined grains: White rice or white pasta							
e. Whole grains: 100% whole grain bread, brown rice, whole wheat pasta, or other whole grains (such as quinoa, buckwheat, amaranth, millet, barley)							

SWEETS AND SNACKS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Sweet roll, doughnut, pie, cake or cookies							
b. Candy or candy bar							
c. Salty snacks (chips, pretzels, crackers)							

FRUITS AND VEGETABLES	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Cooked vegetables							
b. Raw vegetables							
c. Potato (white)							
d. French fries							
e. Piece of fruit / berries or raisins							

DAIRY/FATS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day	>2-3 x/day
a. Cheese (hard cheese, cream cheese)							
b. Yogurt and/or kefir							
c. Ice cream							
d. Margarine							
e. Salad dressings, mayonnaise							
f. Soy based "dairy" products							
g. Butter							
h. Olive oil							
i. Coconut oil							

PROTEINS	Never	<1x/ wk	1-3 x/wk	4-6 x/wk	Every day	2-3 x/day
a. Red meat (beef, bison)						
b. Pork, ham, bacon						
c. Poultry (chicken, turkey, duck)						
d. Fish or seafood						
e. Nuts and/or seeds						
f. Soy based protein						
g. Pizza						
h. Eggs						
i. Protein smoothie (whey, rice, pea)						

How long have you eaten this way? \_\_\_\_\_

**Lifestyle:**

During a typical day at home and at work I will be sitting (at my desk, in a meeting, in a chair, on a couch) for about \_\_\_\_\_ hours.

I usually exercise \_\_\_\_\_ days per week.

If you do exercise, please indicate in which forms of exercise you participate.

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On days that I exercise my workout is usually \_\_\_\_\_ minutes.

Please rate the following:

Daily energy level:            Excellent    Good    Fair    Poor  
Energy level after exercise:    Excellent    Good    Fair    Poor

**Stress:**

Are you happy with your family life?    Yes    No

Are you happy with your work life?    Yes    No

Daily stress level:                    Very High    High    Moderate    Low    None

Do you ever eat or drink to satisfy your emotions?    Yes    No

Do you have a support system of family and friends? \_\_\_\_\_

What creates stress in your life? \_\_\_\_\_

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**Sleep:**

How many hours do you sleep? \_\_\_\_\_

Do you sleep throughout the night?    Yes    No

Do you wake up feeling rested?    Yes    No

Are you satisfied with your sleep?    Yes    No

Sleep issues:

Trouble falling asleep?            Yes    No

Trouble staying asleep?            Yes    No

Insomnia?                            Yes    No

Have you ever been on a restricted or specific diet program?    Yes    No

If yes, what program and what were the results? \_\_\_\_\_

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**Please read the following paragraph:**

Restoring the body and resolving specific complaints is an ongoing process that will take some time. It is important to understand that your diet and lifestyle directly impacts both your current state of health and your future state of health. My role is to educate you and to offer ideas and recommendations that may help improve your health. However, your health is your responsibility. Therefore, you must be willing to accept full responsibility for your health. Part of this responsibility will be the requirement to prepare more meals at home, eat healthier foods, and live a healthier lifestyle.

**Client Authorization:**

*I understand that Bernard Rosen is not a medical doctor, nor does he prescribe pharmaceutical drugs, nor does he provide medical diagnosis or surgery. He provides holistic nutritional consulting and education utilizing assessments, tests and counseling. The holistic health care philosophy is to do no harm, work on prevention, work on the root of the problem, and work on the whole person. I understand that holistic health care is not intended as diagnosis, prescription, treatment or cure for any disease, mental or physical, and is not a substitute for regular medical care.*

*I request that Bernard Rosen perform an evaluation and set up a program for the purpose of enhancing my health and education. Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care. This includes the right to choose my diet, and to obtain, purchase and use any therapy, regimen, modality, remedy or product recommended by the therapist, doctor, or any practitioner of my choice. The enumeration in this declaration of these rights shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.*

*It will be important that I am involved with my health care and health choices. I understand that all recommendations provided by Bernard Rosen are not intended as treatment or prescription for any disease, or as a substitute for regular medical care. It is important that I continue to communicate with all my doctors during our consultations. It is important that I understand that I am a partner in this process. By signing the form I agree and give Rosen Wellness, LLC my permission to release any information and/or reports to other healthcare professionals in regards to my care.*

By signing below, you acknowledge that any dietary or supplemental suggestions made by Bernard Rosen are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

**I have read the statements above and understand completely and am willing to play an active role in achieving my health related goals:**

Client sign and date:

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