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.
□ Chemotherapy
□ Radiation
□ Laxatives
□ Ulcer medications
□ Antibiotic/Antifungal
□ Erectile Dysfunction medications
□ Hormones
□ Thyroid
□ Relaxants/Sleeping pills
□ Antidepressants
□ Aspirin/Acetaminophen
□ Cortisone/Anti-Inflammatory
□ Anti-diabetic/Insulin
□ Heart medications
□ 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

Have you had a root canal? □No □ Yes How many? _____

Have you been diagnosed with any clinical condition or disease? □ No □ Yes

If yes, what: _____

Have you ever been in a motor vehicle accident? □ No □ Yes
Have you had any non-vehicle accidents or falls? □ No □ Yes
Have you had any blood work performed in the last year? □ No □ Yes
Do you choose to get annual flu shots? □ No □ Yes

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
□ Coffee
□ Tea
□ Soft Drinks
□ Hair Dyes
□ Packaged Food
□ NutraSweet/Sweet n' Low
□ Candy
□ "Normal House Cleaning Products (*not* "green" products)
□ "Normal" Cosmetics (*not* health food store types)

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

What do you normally eat for:

Breakfast:
_____

_____

Lunch:_____

_____

Dinner:_____

_____

Number of snacks during the day: _____

Describe your typical snack(s):

_____

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

_____

_____

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:

_____

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.

_____

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:

Rate the current level of **personal stress** in your life: □ None □ Low □Moderate □ High

Rate the current level of **relationship stress** in your life: □ None □ Low □Moderate □ High

Rate the current level of **health stress** in your life: □ None □ Low □Moderate □ High

Rate the current level of **family stress** in your life: □ None □ Low □Moderate □ High

Rate the current level of **occupational stress** in your life: □ None □ Low □Moderate □ High

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

Do you have a support system of family and friends? _____

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

Do you sleep next to any electronic devices? □ Yes □ No

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

If yes, what program and what were the results? _____

_____

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 and Susana Rosen are not medical doctors, nor do they prescribe pharmaceutical drugs, nor do they provide medical diagnosis or surgery. They provide 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 and/or Susana 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 <u>I am involved</u> with my health care and health choices. I understand that all recommendations provided by Bernard Rosen and/or Susana 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, I acknowledge that any dietary or supplemental suggestions made by Bernard Rosen and/or Susana Rosen are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. I also acknowledge that my physician is my primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that I 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:

_____