



QUANTUM HEALTH

TECHNOLOGIES · CONNECTIONS

See the future, bridge the gap

First name: _____ Last name: _____ Sex: Male Female

My top 3 concerns today about my health (1) _____ (2) _____ (3) _____

How did you hear about the Rejuvenation 21 Plan? _____

Date of Birth: ____ - ____ - ____ Age: _____ City & State born: _____

Phone: _____ (Home) _____ (Work) _____ (Cell) _____

Street _____ City _____ State _____ Zip _____

Number of pounds overweight as seen by yourself? _____

Every day I consume: (1 serving = 1 cup) (Please circle item or check box)

Servings of fresh fruits 5 or more 4 3 2 1 0

Servings of vegetables, salad, and green foods.. 5 or more 4 3 2 1 0

Servings of water (8 oz. cups)..... 5 or more 4 3 2 1 0

Servings of fried foods per day..... 5 or more 4 3 2 1 0

Number of bowel movements per day..... Diarrhea 4 3 2 1 0 Constipated

Number of hours of sleep per night..... 8+ or more 7 6 5 4 3 2 1 0

I usually use the following oils when I cook: Coconut, Olive, Canola, Vegetable, Shortening

I use the following to balance the flora in my gut: Acidophilus, Probiotics, Kefir, Yogurt How often? _____

I use the following sweeteners:

White Sugar, Brown Sugar, Splenda, Sweet-N-Lo, Honey, Stevia, Xylitol How often? _____

I have some of the following symptoms (Check all that apply)

- I suffer from panic attacks
- I have heart palpitations
- Trouble staying focused on my job while working
- Frequent anxiety
- I am often told that I am too serious or intense
- Feel exhausted all the time/ tired for no reason
- I have yellow or thick big toe nails
- Allergies
- Feel dizzy upon standing
- I often feel my best after 6 p.m.
- Short term memory loss/ brain fog
- I am often edgy or pessimistic
- Legs jerk while sleeping
- I have a hard time losing weight
- Low sex drive
- I have indigestion or burning in my stomach after eating
- I sometimes wake up between 3 and 4am
- I crave chocolate or salty foods (circle which)
- I have dark circles under my eyes
- I have elevated triglycerides
- I frequently have nightmares
- I have trouble getting up and out of bed in the morning
- Feel worse after exercising, not energized
- I often suffer from headaches, migraines, and muscles cramps
- I consistently have low blood pressure
- I tend to be cold most of the time
- Light sleeper and/or suffer from insomnia
- My nose runs frequently
- Cold hands or feet
- When I gain weight it is usually around my waist
- My hair is falling out or thinning
- I have a history of "yo-yo" dieting
- I have an energy drop in the afternoon
- I have a voice strain
- I have dry skin
- My eyebrows are thinning
- My pulse is <70 or > 90
- I often feel my heart pounding

- I have missing patches of skin pigmentation
- I have muscle aches or cramps often
- Family history of breast cancer
- Frequent headaches
- My periods are irregular or very heavy
- I have plantar fasciitis/pain on soles of feet
- I nod off easily or have sleep apnea
- Infertility problems
- Muscle aches
- Joint pain
- Red eyes
- Poor vision
- Tremors of hands
- Bell's palsy
- Insomnia
- Difficulty driving at night
- I have heart palpitations
- Bladder irritation
- Bright light sensitivity
- Retinal disease
- Bell's palsy
- Irritable bowel syndrome
- Unexplained rash after tick or spider bite
- Prostate problems (VPH)
- Impotence
- Frequent Urination
- Bladder irritation
- History of ulcers or gastritis
- Frequent heartburn or indigestion with nausea and pain
- Acid reflux after eating
- Frequent use of antacids
- Stomach pain that is relieved by eating
- Frequent belching
- Arm, shoulder, or neck pain

Foul odor to breath and/or white film on tongue Unusually large appetite abdominal gas

- | | |
|---|---|
| <input type="checkbox"/> Do you have premenstrual breast tenderness | <input type="checkbox"/> Do you have premenstrual mood swings |
| <input type="checkbox"/> Do you have premenstrual fluid retention and weight gain | <input type="checkbox"/> Premenstrual headaches |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Severe menstrual cramps |
| <input type="checkbox"/> Do you have heavy periods with clotting | <input type="checkbox"/> Do you have irregular menstrual cycles |
| <input type="checkbox"/> Are you or have you taken any estrogen support | <input type="checkbox"/> Do you have uterine fibroids |
| <input type="checkbox"/> Do you have endometriosis | <input type="checkbox"/> Have you had problems with infertility |
| <input type="checkbox"/> Have you had a miscarriage | <input type="checkbox"/> Started menstruation before age 13 |
| <input type="checkbox"/> Do you have a decreased libido | <input type="checkbox"/> Do you have anxiety or panic attacks |
| <input type="checkbox"/> Right shoulder pain or pain by scapula | <input type="checkbox"/> Do you have a belching problem |
| <input type="checkbox"/> | <input type="checkbox"/> Gallbladder issues |

I have had the health conditions I checked below.

- Frequent Constipation
- High cholesterol
- Bypass surgery
- Stroke
- Asthma
- Pacemaker
- Seizures
- Heart failure
- High blood pressure
- Cancer
- Chronic pain _____ (where)
- Lung disease
- Depression
- Frequent headaches
- Arthritis
- Heart problems
- Diabetes: ___ Type 1 or ___ Type 2 (Age at onset ___) I use insulin ___yes ___no
- Surgeries (date): _____
- Tobacco Use: Never Quit _____ years ago Current user Type of tobacco used _____

What type of estrogen support have you taken? _____

Ideally, how often would you like to be contacted by your weight loss coach?
 Daily Every couple of days Every three-five days I will contact the coach when I have questions

Would you like your coach to text message you? If yes, what number do you receive text messages?
 (_____) _____

Would you like your coach to e-mail you? If yes, what e-mail address do you prefer?

- How much soda and diet soda do you drink in a day?** _____
- How many alcoholic beverages do you consume daily?** _____
- How much white bread and sugar do you consume daily?** _____
- Typically, what color are your bowel movements?** _____
- Do you see bubbles in your urine when you urinate?** _____
- In the next six weeks, do you have any special occasions coming up (vacations, birthdays, anniversaries, etc.) If yes, what type of occasion and when?** _____
- Are you comfortable with cooking and preparing your own meals?** _____
- Do you take any diuretics?** _____
- When was your last menstrual cycle?** _____
- Are you on birth control?** _____
- Have you had an organ transplant?** _____
- Do you have gout?** _____
- Are you pregnant or nursing?** _____

Do you have cancer and/or are you receiving cancer treatments? _____

Are you taking any steroid medications? _____

Medicine/vitamins/herbs: I take the following medications _____

I regularly take these **over-the-counter *drugs, herbs, vitamins:***

I understand that I am receiving wellness coaching for weight loss. I agree that I am receiving suggestions to improve my health. It is my choice and responsibility to improve my health. I understand these are only suggestions and I have not received any guarantees regarding these suggestions.

Signature

Date

Coach