REVCORE WELLNESS

# Client Intake Form

Date: _____

Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____

Email _____

Referred By _____

Are you Currently under Medical Care? _____

Present Complaint or Illness _____

_____

_____

_____

Duration of Complaint or Illness _____

Events Preceding Onset _____

_____

_____

_____

Personal Health Goals _____

_____

_____

Date of Birth ____/____/_____ ❑ Male ❑ Female Age _____

Place of Birth _____ Occupation _____

Marital Status _____

# of Children _____ Ages _____

Have you had any of the following? If yes, briefly describe:

Accidents | Surgery _____

_____

_____

Treatments _____

_____

_____

Are you presently taking any medications? _____

If Yes, please list _____

_____

_____

WOMEN ONLY: Age of Onset Menstruation _____

# of Children _____ Date of Last Period _____

# of Miscarriages _____ Complications _____

Age of Onset Menopause _____ Menopause: ❑ Mild ❑ Severe

MEDICAL HISTORY: Check any diseases that you or your relatives have had:

| Relatives | Arthritis | Asthma | Cancer | Diabetes | Epilepsy | Glaucoma | Gout | Heart Disease | Stroke | High Blood Pressure | Hypo Thyroidism | Kidney Disease | Neurological Disease | Stomach Ulcer | Periodontal Disease | Tuberculosis | Athero-sclerosis | Obesity |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| You | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Siblings | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grandparents | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Check any other illnesses that you now have or have had:

- ☐ Abscesses
- ☐ Acne
- ☐ AIDS/HIV
- ☐ Alcohol Addiction
- ☐ Allergies
- ☐ Alopecia
- ☐ Anemia
- ☐ Attempted Suicide
- ☐ Back Problems
- ☐ Benign Breast Tumor
- ☐ Bleeding Gums
- ☐ Bronchitis
- ☐ Candida Albicans
- ☐ Cataracts
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Covid-19
- ☐ Crohn's Disease
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diphtheria
- ☐ Diverticulosis
- ☐ Drug Addiction
- ☐ Ear Infections
- ☐ Eczema
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Eye Disease
- ☐ Fainting/Dizzy Spells
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Gastritis
- ☐ Gingivitis
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Hay Fever
- ☐ Hearing Problems
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ Hives
- ☐ Insomnia
- ☐ Jaundice
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Major Surgery
- ☐ Measles
- ☐ Menstrual Blood Clots
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Myopia
- ☐ Nervousness
- ☐ Neuralgia
- ☐ Night Blindness
- ☐ Numbness
- ☐ Pancreatitis
- ☐ Parasites
- ☐ Persistent Cough
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Skin Ulcers
- ☐ Skipped Heart Beats
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Vision Problems
- ☐ Other _____
- ☐ Other _____

*Have you received:*

- ☐ Childhood Vaccines
- ☐ Covid-19 Vaccination

The information provided is intended solely for nutritional purposes. The information being sought is of a nutritional nature and NOT a medical diagnosis, prescription, treatment, disease prevention or health assessment. I understand that under the Federal Food, Drug and Cosmetic Act, as amended, Section 201(g)(1), the term "Drug" is defined to mean: Articles intended for the use in the DIAGNOSIS, CURE, MITIGATION, TREATMENT, or PREVENTION of disease. In other words, to "say" that a vitamin, mineral, herb, trace element or amino acid will have any effect on disease or symptoms thereof, that particular nutrient then becomes a DRUG under the law as written. Therefore, any suggested nutrition or supplementation is not intended as primary therapy for any disease or symptom, but is provided solely to improve the quality of foods delivered through the diet. WARNING: You are strongly encouraged to consult your physician before starting a new diet, making changes to your nutritional regimen, beginning supplementation, or starting an exercise program--especially if you have a medical condition, are currently taking medications, or are pregnant or nursing. If you are taking prescription medication, you must consult your physician before making any changes to your dosage or discontinuing use.

I understand and agree to the above statement and I also agree that the information I've provided is true and accurate:

Signature: _____ Date: _____

REVCORE WELLNESS

Client Name: _____

Date: _____

# Health & Wellness Questionnaire

Rate each of the following symptoms based on how you have been feeling in the past 30 days:

| HEAD | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Headaches | ☐ | ☐ | ☐ | ☐ |
| Faintness | ☐ | ☐ | ☐ | ☐ |
| Dizziness | ☐ | ☐ | ☐ | ☐ |
| Insomnia | ☐ | ☐ | ☐ | ☐ |
| Low Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| **EYES** | **None** | **Mild** | **Moderate** | **Severe** |
| Watery or Itchy Eyes | ☐ | ☐ | ☐ | ☐ |
| Swollen, Redden or Sticky Eyelids | ☐ | ☐ | ☐ | ☐ |
| Bags or Dark Circles Under Eyes | ☐ | ☐ | ☐ | ☐ |
| Blurred or Tunnel Vision | ☐ | ☐ | ☐ | ☐ |
| **EARS** | **None** | **Mild** | **Moderate** | **Severe** |
| Itchy Ears | ☐ | ☐ | ☐ | ☐ |
| Earaches, Ear Infections | ☐ | ☐ | ☐ | ☐ |
| Drainage from Ear | ☐ | ☐ | ☐ | ☐ |
| Ringing in Ears | ☐ | ☐ | ☐ | ☐ |
| Hearing Loss | ☐ | ☐ | ☐ | ☐ |
| **NOSE** | **None** | **Mild** | **Moderate** | **Severe** |
| Stuffy Nose | ☐ | ☐ | ☐ | ☐ |
| Sinus Problems | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ |
| Sneezing Attacks | ☐ | ☐ | ☐ | ☐ |
| Excessive Mucus Formation | ☐ | ☐ | ☐ | ☐ |
| **SKIN** | **None** | **Mild** | **Moderate** | **Severe** |
| Acne | ☐ | ☐ | ☐ | ☐ |
| Hives, Rashes, Dry Skin | ☐ | ☐ | ☐ | ☐ |
| Hair Loss | ☐ | ☐ | ☐ | ☐ |
| Flushing, Hot Flashes | ☐ | ☐ | ☐ | ☐ |
| Excessive Sweating | ☐ | ☐ | ☐ | ☐ |
| **HEART** | **None** | **Mild** | **Moderate** | **Severe** |
| Chest Pain | ☐ | ☐ | ☐ | ☐ |
| Irregular or Skipped Heartbeat | ☐ | ☐ | ☐ | ☐ |
| Rapid or Pounding Heartbeat | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| **LUNGS** | **None** | **Mild** | **Moderate** | **Severe** |
| Chest Congestion | ☐ | ☐ | ☐ | ☐ |
| Tight Chest | ☐ | ☐ | ☐ | ☐ |
| Asthma, Bronchitis | ☐ | ☐ | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ | ☐ | ☐ |
| Difficulty Breathing | ☐ | ☐ | ☐ | ☐ |
| **MOUTH/THROAT** | **None** | **Mild** | **Moderate** | **Severe** |
| Chronic Coughing | ☐ | ☐ | ☐ | ☐ |
| Canker Sores | ☐ | ☐ | ☐ | ☐ |
| Gagging, Frequent Need to Clear Throat | ☐ | ☐ | ☐ | ☐ |
| Sore Throat, Hoarseness, Loss of Voice | ☐ | ☐ | ☐ | ☐ |
| Swollen or Discolored Tongue, Gums, Lips | ☐ | ☐ | ☐ | ☐ |

| DIGESTIVE TRACT | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Nausea, Vomiting | ☐ | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ | ☐ |
| Bloated Feeling | ☐ | ☐ | ☐ | ☐ |
| Belching, Passing Gas | ☐ | ☐ | ☐ | ☐ |
| Heartburn | ☐ | ☐ | ☐ | ☐ |
| Stomach Pain or Burning | ☐ | ☐ | ☐ | ☐ |
| **JOINTS/MUSCLES** | **None** | **Mild** | **Moderate** | **Severe** |
| Pain or Aches in Joints | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ |
| Stiffness or Limitation of Movement | ☐ | ☐ | ☐ | ☐ |
| Feeling of Weakness or Tiredness | ☐ | ☐ | ☐ | ☐ |
| Pain or Aches in Muscles | ☐ | ☐ | ☐ | ☐ |
| **WEIGHT** | **None** | **Mild** | **Moderate** | **Severe** |
| Binge Eating/Drinking | ☐ | ☐ | ☐ | ☐ |
| Craving Certain Foods | ☐ | ☐ | ☐ | ☐ |
| Excessive Weight | ☐ | ☐ | ☐ | ☐ |
| Water Retention | ☐ | ☐ | ☐ | ☐ |
| Underweight | ☐ | ☐ | ☐ | ☐ |
| Compulsive Eating | ☐ | ☐ | ☐ | ☐ |
| **ENERGY/ACTIVITY** | **None** | **Mild** | **Moderate** | **Severe** |
| Fatigue, Sluggishness | ☐ | ☐ | ☐ | ☐ |
| Apathy, Lethargy | ☐ | ☐ | ☐ | ☐ |
| Hyperactivity | ☐ | ☐ | ☐ | ☐ |
| Restlessness | ☐ | ☐ | ☐ | ☐ |
| **MIND** | **None** | **Mild** | **Moderate** | **Severe** |
| Poor Memory | ☐ | ☐ | ☐ | ☐ |
| Confusion, Poor Comprehension | ☐ | ☐ | ☐ | ☐ |
| Difficulty in Making Decisions | ☐ | ☐ | ☐ | ☐ |
| Stuttering or Stammering | ☐ | ☐ | ☐ | ☐ |
| Slurred Speech | ☐ | ☐ | ☐ | ☐ |
| Learning Disabilities | ☐ | ☐ | ☐ | ☐ |
| Poor Concentration | ☐ | ☐ | ☐ | ☐ |
| Poor Physical Coordination | ☐ | ☐ | ☐ | ☐ |
| **EMOTIONS** | **None** | **Mild** | **Moderate** | **Severe** |
| Mood Swings | ☐ | ☐ | ☐ | ☐ |
| Anxiety, Fear, Nervousness | ☐ | ☐ | ☐ | ☐ |
| Anger, Irritability, Aggressiveness | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ |
| **OTHER** | **None** | **Mild** | **Moderate** | **Severe** |
| Frequent Illness | ☐ | ☐ | ☐ | ☐ |
| Frequent or Urgent Urination | ☐ | ☐ | ☐ | ☐ |
| Swollen Prostate | ☐ | ☐ | ☐ | ☐ |
| Genital Itch or Discharge | ☐ | ☐ | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ | ☐ | ☐ |

How many glasses of water, on average, do you drink per day: _____

How many hours per night, on average, do you sleep: _____

How often per week, on average, do you exercise/stretch: _____

How often per week, on average, do you go out to eat: _____

949.505.5152
30021 Tomas, Suite 300
Rancho Santa Margarita, CA 92688
www.revcorewellness.com

# Disclosure, Liability and Consent Form

Welcome to RevCore Wellness. As you know, I (Diane Wendell, C.N.) am a practitioner of nutrition. I am not a licensed physician, nor are nutrition services licensed by the state. The idea behind nutrition is that: The nutrients found in foods, and when necessary, via supplementation, can be supportive of health, enhancing quality of life and well-being.

As a practitioner of nutrition and health coach, we will provide you with the following kinds of services:

- Diet and nutrition evaluation
- Individualized dietary and supplementation guidance appropriate to your lifestyle and environment
- Education and research on your health concerns
- Non-diagnostic lab tests to determine appropriate diet
- Health support complementary to that provided by licensed professionals

My training and education includes:

- Clinical Nutritionist and Traditional Naturopath from the College of Natural Health
- Applied Clinical Nutrition and Advancement in Clinical Nutrition from the International Academy of Integrated Medicine
- Microscopy for Biological Transmutation from Life Science Fellowship Study
- Certified First Line Therapist and Therapeutic Lifestyle Counselor (TLC) Center of Excellence for Chromic Disease

In order to use my services, California state law requires that you acknowledge receipt of the information provided in this form and that you sign it. You will receive a copy. All information is confidential.

My services in nutrition are alternative or complementary to healing arts that are licensed by the State of California under Sections 2053.5 and 2053.6 of California's Business and Professions Code.

I [the client] understand that RevCore Wellness is a nutritional counseling service that is not intended or licensed to diagnose, treat or cure any diseases, prevent, diagnose, alleviate or treat any medical conditions, disease, physical or mental ailments or pain or infirmities. Furthermore, I [the client] understand that RevCore Wellness will not give medical advice, nor perform any invasive procedures. The treatment you will be receiving is alternative or complimentary to the healing art services that are licensed by the state of California.

If you ever have any concerns about the nature of my services or our work together, please contact me right away. I recommend that you inform your medical doctor that you are receiving nutrition services.

## Waiver and Release for Nutrition Counseling

RevCore Wellness and its representatives do not diagnose disease. You should consult a Physician before undergoing any dietary or food supplement changes. Any recommendations you follow for changes in diet, including but not limited to the use of food supplements are entirely your responsibility.

In consideration of my [the client] participation in nutrition counseling and consumption of any nutritional supplements, I [the client] hereby accept all risk to my health and of my injury or death that may result from such participation and I hereby release RevCore Wellness, its employees and representatives from any liability to me, my personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness or injury to my person, including my death, that may result from or occur during my participation in nutrition counseling, whether caused by negligence of RevCore Wellness, its employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from my negligent or intentional act or omission while participating in the described nutrition counseling session.

## Acknowledgement and Consent to Receive Services

I [the client] have carefully read and understand the above disclosure about the nutrition services offered by Diane Wendell/RevCore Wellness and their training and education. I have discussed the nature of the services to be provided. I understand that Diane Wendell is not a licensed physician and that nutrition services are not licensed by the state. I understand that it is my responsibility to maintain a relationship for myself/my child with a medical doctor of licensed health provider. I have consent to use the services offered by Diane Wendell/RevCore Wellness and agree to be personally responsible for the fee in connection with the services provided to me. I will provide 24-hour notice if an appointment must be missed or will pay for the missed session. I am here as an individual on my own behalf.

Signature of Client/Guardian: _____ Date: _____

Print Name of Client/Guardian: _____ Relationship to Client, if minor: _____

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# Consent for Live Blood Cell Demonstration

The Live Blood Cell Demonstration in which you are about to participate is designed to help educate you about the way in which your diet, exercise, and life style affect your health. Many people are told to "eat right and exercise". This demonstration is intended to help motivate you to make those changes, because you actually see what may be happening in your body on a cellular level.

Here's how the demonstration works: A qualified technician will take a one-drop sample of blood, generally from the fingertip, then placed under a microscope, a magnified image of this blood will be shown to you on a video monitor.

## PLEASE READ CAREFULLY

I understand that the Live Blood Cell Demonstration will provide me with a graphic illustration of my live blood cell condition. I understand that this Demonstration is not a medical test, nor any medical diagnostic information to be derived or implied by this demonstration. I understand that my lifestyle, eating habits, nutritional balance, and mental state may affect what I see and therefore, I may get varying results if I repeat the tests over various periods of time.

I authorize the microscopist to use a lancet to obtain the drop of blood for the demonstration, using OSHA approved guidelines. I agree to hold harmless RevCore Wellness the nutritional counselor and the independent microscopist permission to include results of this demonstration in any statistical or research study. Any suggested nutrition is not intended as primary therapy for any disease of symptom, but rather is intended as an added schedule of enzymes and nutrients provided solely to upgrade the quality of foods delivered through the diet.

By my signature below, I understand and agree to the terms above:

Signature of Client/Guardian: _____ Date: _____

Print Name of Client/Guardian: _____ Relationship to Client, if minor: _____