954 Lake Baldwin Lane, Orlando, FL 32814
Ph: 407-478-9797 Fax:407-478-9798
www.sajune.com

INTEGRATIVE HOLISTIC HEALTH CONSULT

Self-Assessment/ Goal Setting Form

Name:_____Date of Birth :_____

Phone:_____Email _____Today's Date:_____

GENERAL HEALTH:

Please rate the following on a scale of 1-10. YOU CAN LIST A RANGE WHERE APPROPRIATE.:

For sleep, energy and mood, 10 means you feel you are 100% optimal and happy with that particular area of your health.

1. Sleep _____/8 (How many hours of solid, deep, uninterrupted sleep)
2. Energy _____/10 in AM _____/10in PM
3. Mood _____/10 Briefly describe _____

For pain, GI symptoms and anxiety, 10 means you are the worst and 0 means you are free of that symptom completely.

4. Pain _____/10 Where is your pain? _____
5. GI Gastrointestinal symptoms_____/10 List GI symptoms:_____
6. Anxiety _____/10 Briefly describe _____

HISTORY:

Medical Conditions_____
Hospitalizations_____
Surgeries_____
ALLERGIES to Medications or other_____

Please list any **medications/ hormones** you are taking:

_____
_____
_____
_____

Please list any **supplements and brands** you are taking:

_____
_____
_____
_____
_____

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Nutrition: ***Measure and optimize to activate your metabolism and immune system !***

1. What percentage of your diet consists of vegetables? <10% 20-25% 40-55% >55%+
2. Have you ever had a blood test to test the nutrient levels in your cells? YES NO
    a. Are you interested in such a blood test ? YES NO
3. Do you consume cow's dairy products? YES NO Please list _____
4. Do you eat **ORGANIC** ? YES NO Please indicate percentage of organic food _____
5. List any **processed/ man-made foods** (cans, boxes, fast-food) you consume
   _____
   _____
   _____
6. List **RAW** foods and juices consumed daily
   _____
   _____
   _____

Hormones: ***Measure and optimize thyroid and adrenals to prevent disease !***

1. Are you interested in measuring your hormone levels YES NO
2. Have you noticed changes in **focus and mental clarity**? YES NO
    a. Please rate focus on scale 1-10 _____
3. Have you noticed any thinning or **changes in your hair** (head or body)? YES NO
    a. Please rate hair loss on scale 1-10 _____
4. Are you having any issues with **mood swings/ irritability**? YESNO
    a. Please rate symptoms on scale 1-10 _____
5. Are you experiencing any problems with **sexual drive or performance?** YES NO
    a. Please rate on scale 1-10 _____
6. Are you experiencing **Hot flashes or night sweats**? YES NO
    a. How many per 24 hour day _____
7. Do you have problems with **allergies** (rash, hives, food allergies, sneezing, running nose, eczema, etc) YES NO
    a. Please rate on scale 1-10 _____
8. Have you ever been told that your thyroid levels are "Normal" while you have symptoms of low thyroid ? YES NO

Mind: ***Slow down and Devote 3 months to yourself !***

1. List TOP daily stressors _____
2. What activities give you joy, happiness ? _____
3. How often you do these activities/ _____How often do you play ? _____
4. List any tools you use to combat stress _____
5. Rate your daily stress level over last 10 years on scale of 1-10 _____
6. **Have you learned the Heart-Math method of controlling internal stress ? YES NO**

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Body: ***Get oxygenated, pain free and moving !***

1. Have you ever had a measurement of your body composition (body fat, muscle)? YES NO
2. **Do you use conscious breathing and oxygenation methods? YES NO**
3. Are you content with your muscle strength and tone? YES NO
4. Are you content with your weight/ body fat? YES NO
5. Are you currently following an exercise program? YES NO
    a. Briefly describe: _____

6. If looking to make changes in your physique, do you have a time frame in which you'd like to accomplish this? _____

Toxins: ***Get rid of barriers to optimal health !***

1. Approximately, how many ounces of water do you drink in a day? _____
2. Is your water de-chlorinated and filtered for microorganisms? YES NO
3. How many bowel movements are you having per day? _____
4. Are you exposed to **cell phone** daily? _____ **WiFi** ? _____
5. How many hours per day are you exposed to **light** from computer screen/cell phones? _____
6. Does your home have a **smart meter**? YES NO
7. Have you had any **dental issues** or dental work done (fillings, root canals, gum disease, etc)
    a. Please describe_____
8. Do you have Gastric Symptoms (IBS, heartburn, bloating, indigestion, abdominal cramping, diarrhea, constipation? YES NO
9. Do you have allergies, sinus problems, rashes, eczema, hives? YES NO
10. Have you ever done a cleanse of bowel, liver and gallbladder? YES NO

GOALS: Please list 3 symptoms or medical issues that you would like to improve or resolve in 90 days:

1. _____
2. _____
3. _____

What is your preferred mode of communication for Telehealth Consult?

☐ Phone ☐ What's App ☐ Face Time

MEDICAL DISCLAIMER: Always consult your physician before beginning any health program. This general information is not intended to diagnose any medical condition or to replace your healthcare professional.

Date _____Signature:_____