

# New Patient Paperwork



**YOUNG WELLNESS THERAPY**  
TALK THERAPY + HEALTH COUNSELING

Patient Name	
DOB	
Phone Number	
Email	

How did you hear about us?	
	Referral:
	Online:
	Other

Health Goals	Primary Symptoms	Current/Past Diagnoses

# New Patient Paperwork (pt 2)



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How would you describe a typical day of your DIET?	
Allergies	
Weekday Environment	
Weekend Environment	
Physical Activity	
Use of natural products in the home?	Circle:      YES      NO      PARTIALLY
Daily Stress Levels	Circle:   No stress   Minimal   Moderate   High   Extremely High
How do you cope with stress?	
What do you consider your biggest hurdle?	

[illegible]

# New Patient Paperwork (pt 4)

Medications

Supplements

# New Patient Paperwork (pt 5)

Most days, I feel:

I believe my current diet makes me feel:

Overall, my past experiences have made me:

I have sought help before from:

I describe most of my relationships as:

I describe my home life as:

I describe my work life as:

I consider my inner dialog to be:

I consider my outlook on life to be:

Things that make me happy:

I spend \_\_ time on electronics a day:

I spend \_ time outdoors each day:

I'm surrounded by the following chemicals often:

I feel its most important my providers know that:

I learn best by:

I am most successful at or proud of: