Ultimate Wellness Inc. – S.I.T Questionnaire

This Questionnaire is extremely detailed. The more I know about what's going on for you, the better we can develop a treatment plan. Please provide as much information as you can, even if it seems unrelated to your reason for coming in.

Please list any words, subjects, emotional triggers, or physical boundaries your practitioner should be aware of _____

Who are the core, most important people in your life? _____

_____

Please rate how truthful each statement is, (10 being 100% true)

Physical Health:

I have lots of energy and stamina	1	2	3	4	5	6	7	8	9	10
I primarily have deep and restful sleeps	1	2	3	4	5	6	7	8	9	10
My digestion has regular bowel movements and no pain/bloating	1	2	3	4	5	6	7	8	9	10
I am proud of my eating habits	1	2	3	4	5	6	7	8	9	10
I intentionally move my body through exercise more than 3x/week	1	2	3	4	5	6	7	8	9	10
I'm happy with my sex drive	1	2	3	4	5	6	7	8	9	10
I'm happy with my sex life	1	2	3	4	5	6	7	8	9	10
I have a healthy relationship with my menstrual cycle	1	2	3	4	5	6	7	8	9	10
My menstrual cycle does not cause me pain	1	2	3	4	5	6	7	8	9	10

Spiritual/Emotional Health:

I have my own hobbies that bring me joy	1	2	3	4	5	6	7	8	9	10
I have a daily meditation/prayer/gratitude practice	1	2	3	4	5	6	7	8	9	10
The thoughts I have toward my body are positive	1	2	3	4	5	6	7	8	9	10
I enjoy spending time in silence with myself	1	2	3	4	5	6	7	8	9	10
I am a trusting person	1	2	3	4	5	6	7	8	9	10
I have a strong community around me	1	2	3	4	5	6	7	8	9	10
I feel supported + encouraged by my romantic partner *(if applicable)*	1	2	3	4	5	6	7	8	9	10
I feel valued in my relationships	1	2	3	4	5	6	7	8	9	10
There are people who do not deserve my forgiveness	1	2	3	4	5	6	7	8	9	10
I often worry about what people think of me	1	2	3	4	5	6	7	8	9	10
I feel confident expressing my needs/wants	1	2	3	4	5	6	7	8	9	10

I have a general sense of pride about who I am 1 2 3 4 5 6 7 8 9 10

I spend too much time watching TV/Surfing social media 1 2 3 4 5 6 7 8 9 10

I am excited about my future 1 2 3 4 5 6 7 8 9 10

How *and how often* do you move your body/exercise/play? _____

_____

Do you have a daily commitment, practice, or ritual? Explain: _____

_____

What areas of your life are you most proud of? Explain: _____

_____

Please list the physical symptoms (pain, illness, etc.) you're looking to resolve: _____

_____

Please rate physical pain (1 being minor, 10 being unbearable) 1 2 3 4 5 6 7 8 9 10

Please list any emotional symptoms you're looking to resolve:

Does any of these symptoms worsen with certain activities, environments, people or circumstances? Explain: _____

_____

Have you sought other professional assistance? (Please list what has worked and has not.) _____

_____

Are you aware of any prenatal or birth trauma you or your mother experience during her pregnancy or labor? Please explain: _____

_____

At the end of 4-7 S.I.T. sessions together, what would need to happen, and would you need to feel for you to know the time and financial commitment of working together was 100% worth it? Please explain:

_____

_____

_____

Main Concerns

What brings you to see me today? _____

Approximately when did you begin to see signs of this condition? _____

Has it improved or worsened since then? _____

What sort of measures have you taken to improve your condition, and did it help? _____

_____

Health History

Any allergies? _____

Please provide details of any hospitalizations, including reason and dates: _____

_____

Any serious illness, including single occurrence, recurring or chronic? _____

Please list any current medications, supplements, and herbal remedies: _____

_____

General Health

How do you rate your energy level?

0 1 2 3 4 5 6 7 8 9 10

How do you rate your average stress level?

0 1 2 3 4 5 6 7 8 9 10

Please indicate usage & frequency of the following:

☐ Coffee _____ ☐ Tobacco _____ ☐ Alcohol _____

☐ Recreational Drugs _____ Pop / Sweets _____

Check all that apply:

☐ I'm often thirsty ☐ I prefer my warm drinks ☐ I prefer cold drinks

☐ My body runs hot ☐ My body runs cold ☐ My body runs neutral

☐ I wake with a bitter taste in my mouth ☐ I often get headaches / migraines

Do you exercise? What and how much? _____

Do you enjoy your work? How many hours per week? _____

What do you *love* to do for fun? _____

Body Scan - check all that currently apply

☐ Headache / migraine	☐ Dizziness	☐ Fainting
☐ Stiff neck	☐ Enlarged lymph	☐ Blurred vision
☐ Spots / floaters	☐ Eye pain	☐ Eye pain
☐ Poor night vision	☐ Red / burning / itchy eyes	☐ Dry eyes
☐ Recurring ear infections	☐ Earaches	☐ Ring in ears
☐ Wax buildup	☐ Reduced hearing	☐ Bleeding gums
☐ Sinus infections	☐ Hay fever / allergies	☐ Sore throat
☐ Swollen Glands	☐ Hard to swallow	☐ Bitter taste
☐ Mouth sores	☐ Dry mouth	☐ Frequent thirst
☐ Nose bleeds	☐ Joint pain	☐ Body ache / stiffness
☐ Muscle weakness	☐ Numbness / tingling	☐ Back ache
☐ Knee ache	☐ Wheezing / asthma	☐ Difficulty breathing
☐ Chronic cough	☐ Coughing phlegm	☐ Coughing blood
☐ Frequent colds	☐ Pain / itchy genitalia	☐ Genital discharge
☐ Painful urination	☐ Frequent urination	☐ Frequent urination
☐ Excessive urination	☐ Scanty urination	☐ Blood in urine
☐ Wake up to urinate	☐ Kidney stones	☐ Increased libido
☐ Decreased libido	☐ Heart palpitations	☐ Rapid heartbeat
☐ Irregular heartbeat	☐ Hypertension	☐ Chest pain / tightness
☐ Poor circulation	☐ Swollen ankles	☐ Edema
☐ Nausea	☐ Vomiting	☐ Acid reflux / heartburn
☐ Abdominal pain / cramping	☐ Gas	☐ Bloating
☐ Frequent hiccups	☐ Bad breath	☐ Poor appetite
☐ Ravenous appetite	☐ Hunger with no desire to eat	☐ Loose or soft stool
☐ Constipation	☐ Alternating loose / constipation	☐ Laxative use
☐ Black stool	☐ Blood in stool	☐ Mucous in stool
☐ Burning anus	☐ Itchy / pain in the anus	☐ Rectal pain
☐ Hives	☐ Rashes	☐ Eczema
☐ Psoriasis	☐ Acne	☐ Itchiness

☐ Dryness ☐ Mole / lump change ☐ Spontaneous sweat

☐ Hot flushes / fever ☐ Bruise easily ☐ Fine hair / falling out

☐ Nails break easily ☐ Cold hands or feet ☐ Cold nose

☐ Aversion to heat ☐ Aversion to cold ☐ Chills

☐ Weight changes ☐ Fatigue ☐ Poor memory

☐ Restful sleep ☐ Light sleep ☐ Hard to fall asleep

☐ Wake easily / early ☐ Dream disturbed sleep ☐ Nightmares

☐ Heavy sleep ☐ Night sweats ☐ Hours of sleep _____

☐ Relax & calm ☐ Sad ☐ Fearful

☐ Depressed ☐ Angry / frustrated ☐ Irritated easily

☐ Anxious ☐ Stressed ☐ Overthink / worry

☐ Forgetful ☐ Manic ☐ Impatient

Check all that apply:

☐ Haemophiliac ☐ Anemia ☐ Epilepsy

☐ Have pacemaker ☐ Serious heart condition ☐ Serious lung condition

☐ Diabetes ☐ Anticoagulant medications ☐ Scheduled surgeries

Dietary Preference

☐ Vegetarian ☐ Vegan ☐ Pescatarian

☐ Pescatarian ☐ Food intolerances: _____

Pain Assessment

Please describe any acute or chronic injuries/pain: _____

Are you currently experiencing pain? ☐ Yes ☐ No

How would you rate the severity of pain?

0 1 2 3 4 5 6 7 8 9 10

Please describe the pain:

☐ Sharp ☐ Burning ☐ Dull ☐ Aching

☐ Shooting ☐ Tingling ☐ Numb

What relieves the pain:

☐ Heat ☐ Cold ☐ Rest ☐ Exercise

☐ Acupuncture ☐ Massage ☐ Chiropractic ☐ Physiotherapy

What aggravates the pain? _____

Expectations of Care

To provide you with the care that you need, it is important to know more about where you are at in your desire to be well, and how you would like to work together:

For your first visit, what are your expectations of the clinic? _____

_____

What are your expectations of me for today and ongoing? _____

_____

Please describe your lifestyle habits that will support your health: _____

_____

Please describe your lifestyle habits that will hinder your health: _____

_____

Please provide any additional comments that you feel is relevant: _____

_____

Men's Health History (if you are Female, skip to section 8)

Have you had a recent physical exam?	☐ Yes	☐ No	
Do you have high cholesterol?	☐ Yes	☐ No	☐ Unsure
Have you recently had any prostate conditions?	☐ Yes	☐ No	☐ Unsure
Do you have or have you had any urinary infections or STD's?	☐ Yes	☐ No	☐ Unsure
Have you ever taken testosterone supplements / drugs?	☐ Yes	☐ No	

How would you define your sexual energy? ☐ Above normal ☐ Normal ☐ Below normal

(If you are a Male, you're done!)

Female Health History

Menstruation History

Age when your period first started:

Usual cycle length (day 1 - day 1, e.g., 28 days:

Are you in menopause? At what age?

Is your cycle:

☐ Regular ☐ Irregular – early / too short ☐ Irregular – late / too long ☐ Irregular – all over the map

Is your flow: ☐ Light ☐ Moderate ☐ Heavy

Menses colour: ☐ Fresh Red ☐ Scarlet Red ☐ Dark Red ☐ Pink ☐ Purple ☐ Brown ☐ Black

Menses Consistency: ☐ Watery-thin ☐ Thick ☐ Average ☐ Clotty

Do you have menstrual pain? ☐ No ☐ Yes – before ☐ Yes – beginning ☐ Yes – during ☐ Yes - end

Type of menstrual pain: ☐ Cramping ☐ Stabbing ☐ Heavy ☐ Dull ☐ Intermittent

Pain relief with: ☐ Pressure ☐ Heat ☐ Cold ☐ Pain killers ☐ Nothing helps

Do you have pre-menstrual symptoms?

☐ Bloating ☐ Bowel movement changes ☐ Mood changes ☐ Nausea ☐ Breast tenderness

☐ Headache / migraine ☐ Acne ☐ Fatigue ☐ Poor sleep ☐ Energy increase ☐ Energy decrease

Ovulation History

Do you have mid-cycle spotting? ☐ No ☐ Yes

Do you have mid-cycle pain?

☐ No ☐ Yes – right side ☐ Yes – left side ☐ Yes – bottom ☐ Yes – abdomen ☐ Yes – low back

Do you ovulate on your own? ☐ Yes ☐ No

Do you notice cervical fluid changes mid-cycle?

☐ No ☐ Unsure ☐ Yes – white ☐ Yes -dry ☐ Yes – clear & stretchy ☐ Yes - watery

Does your energy change around ovulation? ☐ More ☐ Less ☐ No change ☐ Unsure

General Women's Health History

Any vaginal secretions / discharge?

☐ No ☐ Yes – white ☐ Yes – yellow ☐ Yes – green ☐ Yes – pink ☐ Yes – red

Yes – watery ☐ Yes – thick ☐ Yes - sticky

Have you ever had:

☐ Abnormal pap smear; details: _____

☐ Cervical operation; when: _____

☐ Yeast infections; last one: _____

☐ Bladder infections / UTI: _____

☐ Chlamydia: _____

☐ PID: _____

Have you ever been diagnosed with:

☐ Uterine Fibroids ☐ Endometriosis ☐ Polyps ☐ PCOS

☐ Pelvic Adhesions ☐ Prolapsed Uterus ☐ Prolapsed Bladder ☐ Pelvic Abnormalities

☐ Interstitial Cystitis ☐ Pelvic Floor Dysfunction

Contraceptive / Sexual History

Birth Control: ☐ No ☐ Yes When and for how long? _____

IUD: ☐ No ☐ Yes When and for how long? _____

Depo Provera: ☐ No ☐ Yes When and for how long? _____

Pregnancy History

Please list your children:

Name	Gender	Year born	Age

Please list any pregnancies that did not come to term: _____

Are you pregnant now? ☐ Yes ☐ No ☐ Unsure

Please provide any additional comments or concerns: _____

_____

CLIENT AGREEMENT:

I appreciate the opportunity to discuss your current symptoms and concerns. I wish to make it clear that it is not our intention to diagnose, prescribe or cure any specific ailment, but to offer recommendations and information to support you on your journey of transformation. If you require medical assistance, please consult a medical practitioner. Please do not make any adjustments to prescribed medication without the approval of your doctor. If in doubt, please seek your GP's advice.

I am aware that my treatments may include, but is not limited to, one or more of the following: Psychotherapy or Subconscious Imprinting, to improve or maintain my physical, emotion, mental and spiritual wellbeing.

I understand that my practitioner is open to any questions throughout the treatment and that he believes in an open dialogue of discussion concerning the effects and procedures of therapy. I will inform him of any particular areas that I am uncomfortable discussing and any specific issues related to being touched.

In this session, I may discover the "root-cause" of your current symptoms through conversation and muscle testing. The root cause is often a hidden belief or decision you made due to a specific life event, experience, trauma, or influence. I may ask deeper questions to gain a better understanding of the event so I can effectively remove the impact it's had on your subconscious mind and in your current life.

Please know, that I am also a counselling therapist. You have control of the session and will never be pushed to release information you're uncomfortable talking about. Before signing this form, please ask any questions or concerns you may have.

By signing below, you agree that I am not responsible or liable for any adverse side effects, nor am I guaranteeing immediate results. You're also stating that you have had the opportunity to ask questions and agree to receiving the modality of Subconscious Imprinting Technique. Finally, you acknowledge that the practitioner who is representing S.I.T. and Empowered Healers Academy inc. is assumed to operate in an ethical manner, however, their actions are not a reflection of Empowered Healers Academy inc.

☐ I certify that the above medical information is correct to my knowledge, and I consent to treatment. I understand that this form will remain valid, and in effect for the duration of my care.

Client Name: _____

Client Signature: _____ Date: _____

Practitioner Name: _____

Practitioner Signature: _____ Date: _____

After a Subconscious Imprinting Session

It's perfectly normal to experience:

A continued release of emotions. Simply allow yourself to experience and observe the emotions that come up without judgement and especially without trying to change them. It's completely normal to feel angry, irritated, or "off" after this work. Don't worry! This is all part of the process. Remember: Emotions are your body and minds way of communicating with you. Get curious about what's being communicated.

With the subconscious mind, not only are certain emotions experienced, we are also accessing different parts of your brain that have been "sleeping". This can be extremely exhausting. *Honour that.*

Thirsty. Please make sure to drink lots of high-quality water after your S.I.T Session to help release any toxins that your body is working hard to remove.

Hunger. You may experience intense hunger or strange cravings. This is completely normal. Your body worked hard to release the memories and emotions that were addressed in your session. Make sure to give it the fuel it requires.

Pattern Realizations: Often, when certain patterns are uncovered in your life, you will continue to experience additional insights about who you are and *why* you are. You may experience revelations about your past, relationships, belief systems, etc. that are keys to your transformation. Make note of these insights and enjoy the new gift of deeper self-awareness.

Recommended Course of Action/Homework:

_____

_____

_____

_____

While one session will be incredibly valuable, it is recommended committing to a minimum of 4 sessions. Working with a practitioner during your healing journey can be a very empowering and momentous in your evolution.

You're welcome to visit www.SITfeedback.com to let us know how your practitioner did!
We welcome all forms of feedback to ensure our community is operating with the highest integrity.