LIFE·SPAN
HEALTH & WELLNESS CENTERS

Your Pathway to Optimal Health

- Product Recommendations
- Laboratory Test Recommendations
- Assessment Recommendations
- Diet Recommendations
- Exercise Recommendations
- Referral Recommendations
- Life-Span Counselor Notes
- Patient Notes

A Patient's Guide to Optimal Health – The Life-Span Way

Congratulations! You have taken a giant step toward ultimate health!

This booklet is designed to be used by both you and your Life-Span Counselor as you remove the obstacles to your good health. Your Life-Span Counselor will write down recommendations and notes outlining both your initial recommendations and possible pathways for future approaches. You will use these pages to keep track of your progress, document your concerns, and write down any questions you may have.

Always feel free to contact your Life-Span Counselor between your scheduled consultations. Only by working together can you achieve ultimate health!

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Life-Span Counselor

Initial Assessment

Client Name: _____

Blood Type: _____

Time: _____ **Date:** _____

Initial Assessment: _____

_____

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Initial Product Recommendations: _____

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Initial Laboratory Test Recommendations: _____

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continued on next page

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Initial Assessment

(continued)

Client Name: _____

Additional Assessments:

- Adrenal Stress
- Adult Behavior
- Allergic Sinusitis Detailed Questionnaire
- Antacids (for Homeopathic Recommendations)
- Antibiotics (for Homeopathic Recommendations)
- Anticonvulsants(for Homeopathic Recommendations)
- Antioxidants/Multivitamin Deficiency
- Antiretroviral Drugs(for Homeopathic Recommendations)
- Arthritis
- Benign Prostate Hypertrophy
- Calcium Dosages Questionnaire
- Candida
- Cardio/Diuretic Drugs (for Homeopathic Recommendations)
- Cardiovascular Health Risk
- Children's Stress and Behavior
- Chronic Fatigue Syndrome
- Depression – Are You Depressed?
- Depression – Clinical
- Depression – Clinical for Adolescents
- Diabetes
- Dysbiosis
- Exposure Risks
- Fibromyalgia
- First Heart Attack Risk
- Food Allergy
- Geriatric Depression
- Gluten Sensitivity
- Health Assessment Questionnaire
- Hypoglycemia
- Hyperthyroidism
- Leaky Gut Syndrome
- Lifestyle & Risk (Weight Loss) Questionnaire
- Liver Toxicity
- Magnesium Deficiency
- Migraine
- Mineral Testing
- Osteoporosis
- Osteoporosis for Men
- Osteoporosis for Women
- PMS
- Scoff Questionnaire
- Serotonin
- Short ADD/ADHD Questionnaire
- Short Asthma Questionnaire
- Short Delayed, Hidden Food Allergy
- Short Gluten Sensitivity
- Short Insomnia
- Short Osteoporosis Questionnaire for Men
- Short Osteoporosis Questionnaire for Women
- Short Snoring & Sleep Apnea
- Stress
- Toxicity
- Toxicity Risk Assessment
- Wound Care

Diet Changes:

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Elimination Diet Blood Type B Diet Blood Type O Diet

Blood Type A Diet Blood Type AB Diet Other: _____

Exercise Recommendations: _____

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_____

Referrals:

Medical Doctor Counselor Chiropractor Massage Therapist

Other: _____

Pharmacist Notes: _____

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Follow-up Assessment: _____

Client Name: _____

Time: _____ **Date:** _____

Patient Notes: _____

_____

Improvement/ Changes Noted: _____

_____

_____

Continue Current Product Regimen? Yes No See Changes

Additional Product Recommendations: _____

_____

Discontinue these products: _____

Additional Laboratory Test Recommendations: _____

Additional Assessments:: _____

Additional Diet Recommendations: _____

Additional Exercise Recommendations: _____

Additional Referrals:

Medical Doctor Counselor Chiropractor Massage Therapist

Other: _____

Counselor Notes: _____

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Follow-up Assessment: _____

Client Name: _____

Time: _____ **Date:** _____

Patient Notes: _____

_____

Improvement/ Changes Noted: _____

_____

_____

Continue Current Product Regimen? Yes No See Changes

Additional Product Recommendations: _____

_____

Discontinue these products: _____

Additional Laboratory Test Recommendations: _____

Additional Assessments:: _____

Additional Diet Recommendations: _____

Additional Exercise Recommendations: _____

Additional Referrals:

Medical Doctor Counselor Chiropractor Massage Therapist

Other: _____

Counselor Notes: _____

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Follow-up Assessment: _____

Name: _____

Time: _____ **Date:** _____

Patient Notes: _____

_____

Improvement/ Changes Noted: _____

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_____

Continue Current Product Regimen? Yes No See Changes

Additional Product Recommendations: _____

_____

Discontinue these products: _____

Additional Laboratory Test Recommendations: _____

Additional Assessments:: _____

Additional Diet Recommendations: _____

Additional Exercise Recommendations: _____

Additional Referrals:

Medical Doctor Counselor Chiropractor Massage Therapist

Other: _____

Counselor Notes: _____

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Follow-up Assessment: _____

Client Name: _____

Time: _____ **Date:** _____

Patient Notes: _____

_____

Improvement/ Changes Noted: _____

_____

_____

Continue Current Product Regimen? Yes No See Changes

Additional Product Recommendations: _____

_____

Discontinue these products: _____

Additional Laboratory Test Recommendations: _____

Additional Assessments:: _____

Additional Diet Recommendations: _____

Additional Exercise Recommendations: _____

Additional Referrals:

Medical Doctor Counselor Chiropractor Massage Therapist

Other: _____

Counselor Notes: _____

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Progress Notes: _____

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