OC TOTAL WELLNESS

Client Information

Date: _____

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
Email _____
Referred By _____
Present Complaint or Illness _____
_____
_____
Duration _____
Events Preceding Onset _____
_____
_____
Personal Health Goals _____
_____
_____
_____
_____

Date of Birth ____/____/_____ ❑ Male ❑ Female Age _____
Occupation _____
Marital Status _____
# of Children _____ Ages _____
Have you had any of the following? If yes, briefly describe:
Accidents: _____
_____
_____
Surgery: _____
_____
_____
Are you presently taking any medications? _____
If Yes, please list: _____
_____
_____
WOMEN ONLY: Age of Onset Menstruation _____
# of Children _____ Complications _____
# of Miscarriages _____ # of Abortions _____ # of C-Sections _____
Menopause _____

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	Senility
You																		
Father																		
Mother																		
Brothers																		
Sisters																		
Spouse																		
Children																		
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
____ Depression
____ Diphtheria
____ Diverticulosis
____ Drug Addiction
____ Ear Infections
____ Eczema
____ Emphysema
____ Endometriosis
____ Excessive Fatigue
____ 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
____ Migraines
____ Mononucleosis
____ Multiple Sclerosis
____ Mumps
____ Myopia
____ Nervousness
____ Neuralgia
____ Night Blindness
____ Numbness
____ Pancreatitis
____ Persistent Cough
____ Pneumonia
____ Polio
____ Psoriasis
____ Rheumatic Fever
____ Rheumatoid Arthritis
____ Scarlet Fever
____ Sciatica
____ Skin Ulcers
____ Skipped Heart Beats
____ Stroke
____ Thyroid Disease
____ Ulcerative Colitis
____ Vision Problems
Other _____
Other _____

Have you received:
____ Childhood Vaccines
____ Covid-19 Vaccination

The above information is provided to this facility for nutritional information. The information being sought is of a nutritional nature and NOT a medical diagnosis, prescription, treatment, disease prevention or health assessment. I understand: According to 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 upgrade the quality of foods delivered through the diet. WARNING: You may wish to consult your physician before beginning a diet or making changes in your diet, nutritional supplementation or exercise program, especially if you have a medical condition, are taking any medications, or are pregnant or nursing. If you are currently taking prescriptive medication, you must discuss any changes with your physician before discontinuing or altering your dosage.

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

Signature: _____ Date: _____

OC | TOTAL WELLNESS

Client Name: _____

Date: _____

Health Evaluation Questionnaire

Rate each of the following symptoms based on your typical health profile in the past 30 days.

POINT SCALE:

⓪ = **Never** or **almost never** have the symptom ❖ ① = **Occasionally** have it, effect is **not** severe
② = **Occasionally** have it, effect **is** severe ❖ ③ = **Frequently** have it, effect is **not** severe
④ = **Frequently** have it, effect **is** severe

HEAD	Headaches ⓪ ① ② ③ ④ Faintness ⓪ ① ② ③ ④ Dizziness ⓪ ① ② ③ ④ Insomnia ⓪ ① ② ③ ④
EYES	Watery or itchy eyes ⓪ ① ② ③ ④ Swollen, redden or sticky eyelids ⓪ ① ② ③ ④ Bags or dark circles under eyes ⓪ ① ② ③ ④ Blurred or tunnel vision ⓪ ① ② ③ ④
EARS	Itchy ears ⓪ ① ② ③ ④ Earaches, ear infections ⓪ ① ② ③ ④ Drainage from ear ⓪ ① ② ③ ④ Ringing in ears ⓪ ① ② ③ ④ Hearing Loss ⓪ ① ② ③ ④
NOSE	Stuffy nose ⓪ ① ② ③ ④ Sinus problems ⓪ ① ② ③ ④ Hay fever ⓪ ① ② ③ ④ Sneezing attacks ⓪ ① ② ③ ④ Excessive mucus formation ⓪ ① ② ③ ④
MOUTH/THROAT	Chronic coughing ⓪ ① ② ③ ④ Gagging, frequent need to clear throat ⓪ ① ② ③ ④ Sore throat, hoarseness, loss of voice ⓪ ① ② ③ ④ Swollen or discolored tongue, gums, lips ⓪ ① ② ③ ④ Canker sores ⓪ ① ② ③ ④

SKIN	Acne ⓪ ① ② ③ ④ Hives, rashes, dry skin ⓪ ① ② ③ ④ Hair loss ⓪ ① ② ③ ④ Flushing, hot flashes ⓪ ① ② ③ ④ Excessive sweating ⓪ ① ② ③ ④
HEART	Chest pain ⓪ ① ② ③ ④ Irregular or skipped heartbeat ⓪ ① ② ③ ④ Rapid or pounding heartbeat ⓪ ① ② ③ ④
LUNGS	Chest congestion ⓪ ① ② ③ ④ Asthma, bronchitis ⓪ ① ② ③ ④ Shortness of breath ⓪ ① ② ③ ④ Difficulty breathing ⓪ ① ② ③ ④
DIGESTIVE TRACT	Nausea, vomiting ⓪ ① ② ③ ④ Diarrhea ⓪ ① ② ③ ④ Constipation ⓪ ① ② ③ ④ Bloated feeling ⓪ ① ② ③ ④ Belching, passing gas ⓪ ① ② ③ ④ Heartburn ⓪ ① ② ③ ④ Intestinal/stomach pain ⓪ ① ② ③ ④
JOINTS/ MUSCLES	Pain or aches in joints ⓪ ① ② ③ ④ Arthritis ⓪ ① ② ③ ④ Stiffness or limitation of movement ⓪ ① ② ③ ④ Feeling of weakness or tiredness ⓪ ① ② ③ ④ Pain or aches in muscles ⓪ ① ② ③ ④

WEIGHT	Binge eating/drinking ⓪ ① ② ③ ④ Craving certain foods ⓪ ① ② ③ ④ Excessive weight ⓪ ① ② ③ ④ Water retention ⓪ ① ② ③ ④ Underweight ⓪ ① ② ③ ④ Compulsive eating ⓪ ① ② ③ ④
ENERGY/ ACTIVITY	Fatigue, sluggishness ⓪ ① ② ③ ④ Apathy, lethargy ⓪ ① ② ③ ④ Hyperactivity ⓪ ① ② ③ ④ Restlessness ⓪ ① ② ③ ④
MIND	Poor memory ⓪ ① ② ③ ④ Confusion, poor comprehension ⓪ ① ② ③ ④ Difficulty in making decisions ⓪ ① ② ③ ④ Stuttering or stammering ⓪ ① ② ③ ④ Slurred speech ⓪ ① ② ③ ④ Learning disabilities ⓪ ① ② ③ ④ Poor concentration ⓪ ① ② ③ ④ Poor physical coordination ⓪ ① ② ③ ④
EMOTIONS	Mood swings ⓪ ① ② ③ ④ Anxiety, fear, nervousness ⓪ ① ② ③ ④ Anger, irritability, aggressiveness ⓪ ① ② ③ ④ Depression ⓪ ① ② ③ ④
OTHER	Frequent illness ⓪ ① ② ③ ④ Frequent or urgent urination ⓪ ① ② ③ ④ Genital itch or discharge ⓪ ① ② ③ ④

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

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

601 Parkcenter Drive, Suite 103
Santa Ana, California 92705
714.508.9999
www.octotalwellness.com

Disclosure, Liability and Consent Form

Welcome to OC Total Wellness. As you know, we are a practitioner of nutrition and health coach. We are not licensed physicians, 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

Our training and education includes:

Diane Wendell, C.N., C.N.M.:

- 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

Cynthia Romero, C.H.C., C.N.M.:

- Certified Health Coach from the Health Coach Institute (HCI)
- HCI Certified Life Coach from the Health Coach Institute
- Certified in Live & Dry Blood Analysis and Applied Nutritional Microscopy from NeoGenesis Systems

In order to use our 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 and we will keep the original documents in our records for at least three years. All information is confidential.

Our 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 OC Total 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 OC Total 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 OC Total Wellness' services or our work together, please contact us right away. We recommend that you inform your medical doctor that you are receiving nutrition services.

Waiver and Release for Nutrition Counseling

OC Total 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 OC Total 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 OC Total 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 OC Total Wellness and their training and education. I have discussed the nature of the services to be provided. I understand that OC Total Wellness' nutritionists are 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 OC Total 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 Demonstration

The Live Blood 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 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 OC Total 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: _____

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Client Consultation Schedule

Initial Consultation (1.5 - 2 hours)……Initial Consultation

Testing
- ☐ Blood Pressure
- ☐ Zinc Test
- ☐ pH Test
- ☐ Bio Impedance Analysis

Evaluation
- ☐ Live Blood Analysis
- ☐ Dry Blood Sample

Nutritional Consultation
- ☐ In-depth Consultation with Nutritional Program
- ☐ Send out for additional Lab Testing, if necessary

1st Follow-Up Appointment (1 hour)……Follow-Up Consultation
(Scheduled **3 weeks** from previous appointment)

Testing
- ☐ Blood Pressure
- ☐ Zinc Test
- ☐ pH Test

Evaluation
- ☐ Live Blood Analysis
- ☐ Life Style and Meal Plan

Nutritional Consultation
- ☐ Adjust Nutritional Program
- ☐ Analyze and Discuss Lab Results (computerized detailed report on Blood Test results)

2nd Follow-Up Appointment (1 hour)……Follow-Up Consultation
(Scheduled **3 weeks** from previous appointment)

Testing
- ☐ Blood Pressure
- ☐ Zinc Test
- ☐ pH Test
- ☐ Bio Impedance Analysis

Evaluation
- ☐ Live Blood Analysis

Nutritional Consultation
- ☐ Adjust Nutritional Program

Continuing Consultations
Additional follow-up appointments as needed based on client's needs and concerns. Biomeridian Analysis, Thermography Screenings, and/or other services may be recommended on a per-client basis.

*Products purchased are an additional expense.

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Nutritional Services Offered

Initial Consultation with Diane Wendell, C.N., C.N.M. (apx. 1.5 hours)	$299
Follow-Up Consultation with Diane Wendell, C.N., C.N.M. (apx. 45 - 60 minutes)	$199
Phone Consultation with Diane Wendell, C.N., C.N.M.	$145
Initial Consultation with Cynthia Romero, C.H.C., C.N.M. (apx. 1.5 hours)	$245
Follow-Up Consultation with Cynthia Romero, C.H.C., C.N.M. (apx. 45 - 60 minutes)	$145
Biomeridian Analysis with Consultation	$245
Thermal Imaging: Women's Health Screening	$349
Thermal Imaging: Men's Health Screening	$349
Thermal Imaging: Full Body Female -or- Male Screening (head-to-toe)	$449
Thermal Imaging: Breast & Lymph Screening	$249
B.I.A. (Bioelectrical Impedance Analysis) Testing Only	$ 50
Zaaz Oscillation Therapy Session	$ 20
Zaaz Oscillation Therapy - 10 Session Membership Card (a $20 savings)	$180
BEMER Session – Single Modality	$ 25
BEMER Session – Dual Modality	$ 30
BEMER - 10 Session Membership Card (a $50 savings)	$200
TDP Mineral Lamp Session	$ 20

*as of Sept 2024