THANYAPURA
PHUKET

HEALTH AND WELLNESS CONSULTATION

Personal information

Name_____ Visit Number_____Room Number _____
Arrival Date _____ DOB_____Age_____
Departure Date _____ Nationality_____Occupation_____
No. of night stay _____ Email_____
Retreat _____ Telephone/ Mobile Phone _____

Weight _____ Height _____

Blood Pressure_____mm/Hg Resting Pulse_____bpm.
Allergies:_____

Medical History

Previous Health Condition

Please list any previous history of illnesses/ injuries you had been experiencing.

Operation History

Please list any surgical history and date

Family Heath History

Please list any health condition in your family

Current Health Condition

Please list any **present** health complaints, current illness, or any injuries you are experiencing.

Medications

List all prescribed medications, supplements, herbs, including dosage and frequency taken

Lifestyle Assessment

Do you smoke cigars, cigarettes, e-cigarettes or a pipe? Yes/No amount per day_____

Do you drink Alcohol? Yes/No Amount Per day_____

Do you use any recreational drugs? _____type? _____

High risk or multiple sex partners?

Physical Activity

How often do you exercise per week?_____For how long?_____hours

What type of exercise do you do?

Do you practice Yoga or meditation?

Muscle and skeletal Health

Do you have any stiffness, restriction, or pain while movement? When did it appear and how long has it lasted?

Reproductive Health

Do you have any concerns with your sexual health or performance?

Do you have any of the following?

Bloating Breast Tenderness Water Retention Weight Gain/ Weight Loss Insomnia Hair Loss
Night Sweats Mood swings Hot Flashes Dry Skin Difficulty Achieving Orgasm
Erectile Dysfunction Low Libido

Female Reproductive Heath

Do you have a regular menstrual cycle?
Date of Last menstruation?
Menopause date?

Digestive Health

Circle any of the following that you suffer from:

IBS Nausea Bloating Gas Indigestion Heartburn Constipation Diarrhea
Stomach Cramps Stomach Pain Mucous or Blood in stool Bad Breath Hemorrhoids

How many Bowel movements do you have daily? _____ ☐ ☐

Nutrition Assessment

Do you have any food intolerances or food allergy?_____

Do you have any specific diet you follow currently?_____
Is there any ingredient/spice/seasoning that you cannot eat or drink?

Weight history
Minimum weight / when?
Maximum weight/ when?

What is your Feel-good weight?

How Is your Appetite?

Emotional Health

Stress Levels										
1. Work (1-Lowest 10-Highest)	1	2	3	4	5	6	7	8	9	10
2. Personal life (1-Lowest 10-Highest)	1	2	3	4	5	6	7	8	9	10

Emotions

How does stress manifest in you mentally /physically / emotionally ?

What do you do for relaxing?

Sleeping & Energy

How many hours do you sleep per night?	_____Hours
Do you have disturbed sleep? (Difficulty fallingasleep, waking-up early, snoring or sleep apnea?)	☐NO ☐YES_____
Do you use any sleeping aids?	☐NO ☐YES_____
How does your energy fluctuate during the	Morning_____Mid-day_____Evening_____

Goals and Program Objective

What do you hope to achieve from your health program?

How ready are you to make the necessary changes to achieve your goal? (0-10)_____

Additional comments:

Recommendations (This section is For Health and Wellness Advisor)

I hereby declare that the above information is a complete and accurate record of my current health and lifestyle, including all known medical conditions and other information that may be relevant to my undertaking any of the treatments or services at Thanyapura Wellness Center. I am aware that all activities, treatments and programs are undertaken at my own risk. I hereby absolutely and irrevocably release Thanyapura Wellness Center, its employees, representatives, agents or assignees from any claim, legal or otherwise, from accidents, injuries or outcomes that may occur as a result of my participation in any such activities/programs/treatments.

Guest Signature_____ Date _____

Health& Wellness Consultant_____ Date _____