Sunlight Natural Health
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Consultation Sign In and Contact Form

Today's Date _____ Date of Birth _____

Name _____
First M.I. Last

Address _____

_____

City _____

State _____

Zip code _____

Phone _____
Home

_____
Cell

E-mail _____

☐ "*Add me to your email list for Newsletters and updates*."

How did you hear about Sunlight Natural Health and Dr. Janene Martin?

☐ Referral/word of mouth (please let us know who referred you so we can thank them):
_____

☐ Saw sign
☐ Google search
☐ Sunlight Natural Health website
☐ HealthProfessionals.com website
☐ CCBC Women's Expo
☐ Saw flyer posted (please let us know where): _____
☐ WTMD radio ad (what show/time of day?): _____
☐ AANP website
☐ Social Network (specify: Facebook, Twitter, Linked In, etc.)_____

☐ Other: _____

Updated 11/22/17

Introductory Consult Questionnaire

1.What do you hope to achieve by working together?

_____
_____
_____
_____

2.If you had a magic wand and could erase 3 problems, what would they be?

a) _____
b) _____
c) _____

3. When was the last time you felt well?

_____
_____
_____
_____

4. Did something trigger your change in health?

_____
_____
_____
_____

5. Have you made any changes in your eating habits because of your health?

_____
_____
_____
_____

6. How will you know you have received value from our work together?

_____
_____
_____
_____

7. In order to improve your health, how willing are you to:

Rate on a scale of 5 (very willing) to 1 (not willing)

a. _____ Significantly modify your diet
b. _____ Take several nutritional supplements each day
c. _____ Keep a record of everything you eat each day
d. _____ Modify your lifestyle (e.g. work demands, sleep habits)
e. _____ Practice a relaxation technique
f. _____ Engage in regular exercise
g. _____ Have periodic lab tests to assess your progress

Comments:_____

_____

_____

_____

8. How confident are you of your ability to organize and follow through on the above related activities: _____

Rate on a scale of 5 (very confident) to 1 (not confident at all)

If you are not confident of your ability, what aspects of your life lead you to question your capacity to fully engage in the above activities?

_____

_____

_____

_____

9. At the present time, how supportive do you think the people in your household will be to the above changes? _____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive)

Comments:_____

_____

_____

_____

10. How much on-going support and contact (e.g. telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? _____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact)

Comments:_____

_____

_____

_____