Name: ____ (print first and last)

Today's Date: Circle one: Male or Female	Date of Birth: Age:
How did you hear about us?	Occupation:

Considering your overall health, list your biggest complaints:
1.____ When did this start?_______________
2.____ When did this start?_______________
3.____ When did this start?_______________

Current Height:	Current Weight:	Weight most comfortable at?

How many times a week do you consume the following:			
Soda Pop:	Coffee:	Grains:	Alcohol:
Fast Food:	Dairy:	Fruit:	Veggies:
Meat/Poultry:	Fish:	Nuts/Seed:	Cigarettes:
Sweets:	Beans/Legumes:	Recreational Drugs: If so, what kind?	
Any foods you crave: Salty Foods Chocolate Sweets Breads Other			

How many times per week do you exercise? Describe:	
How many ounces of water do you drink daily?	How many bowel movements do you have a day?
Are your bowel movements: ___loose ___well formed ___ loose and formed ___incomplete ___thin ___dry and hard ___need laxatives ___painful	

List all allergies:

List any major illnesses or surgeries you've had and how long ago:
____
____
_

On a scale from 1 to 10, 10 being the highest level of energy, how much daily energy do you have?

In the night, is it difficult to fall asleep or back to sleep? How many hours of sleep do you get each night?

Circle predominate emotions: Happy Nervous Obsessive Depressed Stuck Irritable Angry Even Natured

Circle Yes or No: Are you currently pregnant: Yes or No Are you currently breastfeeding: Yes or No

List any mental or emotional disorders you have been diagnosed with:

Please list all current medications and supplements as well as why you are taking them:

Medication/Supplement	Dosage	Length of Time Taken	Reason

Circle any health issues that you currently have:

Acne	ADD/ADHD	Allergies	Alzheimer’s	Ulcers
Crohn’s	Arteriosclerosis	Arthritis/Joint Pain	Asthma	Neuropathy
Kidney Disease	Stroke	Shingles	Blood Pressure - low	Blood Pressure -high
Bladder issues	Cancer	Candida	Sinus Issues	Multiple Sclerosis
Mental Health	Cholesterol	Miscarriage	Hysterectomy	Colitis/IBS
Constipation	Liver Disease	Menopause	Diabetes	Dizzy Spells
Ear Infections	Ear Ringing	Edema	Emphysema	Epilepsy
Seizures	Migraines	Menstrual Cramps	Alcoholism	Gallstones
Bipolar	Parkinson’s	Nose Bleeds	Skin Issue	Hair Issues
Prostate Issues	Heartburn	Bloating	Acid Reflux	Hemorrhoids
Herpes	Heart Disease	Hives	Hormone Imbalances	PMS
Hypertension	Hyperthyroidism	Hypothyroidism	Hypoglycemia	Impotence
Incontinence	Lupus	Reproductive Issues	Kidney Stones	Pregnant
Mononucleosis	Lyme Disease	Nausea	Pacemaker	Urinary Infections
Have IUD, patch, ring or another form of oral contraceptive				

On a scale from 1 to 10 (10 being very familiar), how familiar are you with holistic/natural living:

I fully understand that the proprietary testing service deals strictly in helping improve general health through better nutritional approaches, improved lifestyle, improved health habits and positive mental attitudes. I fully understand that employees of our proprietary testing service are not licensed physicians and cannot diagnose diseases, prescribe drugs or recommend treatments for specific disease conditions. I understand that all evaluations/analysis performed by are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits, and attitudes. I further understand that all evaluations/analysis cannot determine specific disease conditions, and do not replace the diagnostic services offered by licensed physicians. I certify that our proprietary testing service has not suggested that I cease any medical care I may be undertaking. I understand that decisions I make regarding health care are my responsibility and certify that I will not hold our proprietary testing service responsible for the consequences of my decisions. These services are not a substitute for prompt medical attention needed. Natural attempts will be made to relieve discomforts, but if a medical professional is needed, seek medical attention or verify recommendations with a primary physician. I certify that I am here on this and on any subsequent visits or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation. I have read and understand the foregoing and agree to the terms and conditions set therein. Your privacy is a top priority. We are committed to your Confidentiality of personal information, and securing it with administrative, technical, and physical safeguards. None of your information will ever be sold.

Signature:____ **Date:**________________

Referring Doctor:____