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"The Greatest Wealth is Health"

NEW CLIENT INFORMATION FORM

NAME: _____

History:

List any major illnesses (and approx. dates)

_____

List any surgery/operations with approximate date

_____

List any accidents or injuries

_____

Marital Status: M S D W Spouse's Name: _____

Family History of serious illnesses (circle all that apply)

CANCER HEART DIABETES OTHERS: _____

_____

Metal Dental Fillings? _____ Pets? _____

What can we do for you today?

_____

How did you hear about us? _____

Rate: Initial consultation up to 1 hr. (No Charge)

Subsequent consultations/Crafting Formulas: $20.00 for half hour

PAYMENT DUE AT TIME OF SERVICE

SIGNATURE: _____ Date: _____

Nutritional Consent Informed Consent

According to Federal Food, Drug, and Cosmetic Act as amended, Section 201 (g) (1), the term “DRUG” is defined to mean “Articles intended for use in Diagnosis, Cure, Mitigation, Treatment or Prevent of Disease. “A Vitamin, Mineral, Trace Element, Amino Acid, Herb or Homeopathic remedy cannot be misrepresented or be classified as a “DRUG” by anyone even though it may have an effect on a disease process or symptom.

Therefore, please be advised that any suggested nutritional or dietary advice is not as a primary treatment and/or therapy for any disease or body symptom.

Counseling is provided solely to upgrade the quality of foods in order to supply nutrition supporting the physiological and biomechanical process of the body.

I have read and understand the above:

Signature: _____ **Date**: _____

Medications

DRUGS	PRESCRIPTIONS FOR:	HOW LONG
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUGS	PRESCRIBED FOR:	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please list any known allergies (ex. Foods, medications, spices, environmental, etc.)

☐ DAIRY	☐ GLUTEN	☐ RAGWEED	☐ SULFA DRUGS
☐ EGGS	☐ MOLD	☐ SHELLFISH	☐ TREE NUTS
☐ GARLIC	☐ PEANUTS	☐ SOY	☐ WHEAT

☐ others _____

SUPPLEMENTS

Please list all vitamins/supplements you are taking and dosage

VITAMINS	BRANDS	DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADRENAL FATIGUE QUICK CHECK

Patients name: _____ Date: _____

Please check next to any of the following that currently apply to you.

☐ Difficulty getting up in the morning

☐ Continuing fatigue, not relieved by sleep or rest

☐ Lethargy, lack of energy to do normal daily activities

☐ Sugar cravings

☐ Salt cravings

☐ Allergies

☐ Digestive Problems

☐ Increased effort needed for everyday tasks

☐ Light-headed or dizzy when standing up quickly

☐ Low Mood

☐ Less enjoyment or happiness with life

☐ Increase PMS

☐ Symptoms worsen if meals are skipped or inadequate

☐ Thoughts are less focused, brain fog

☐ Memory is Poor

☐ Decreased tolerance for stress, noise, disorder

☐ Don't really wake up until after 10:00 am

☐ Afternoon low between 3:00 PM and 4:00 PM

☐ Feel Better after Supper

☐ Get a "Second Wind" in the Evening, and stay up late

☐ Decreased ability to get things done – less productive

☐ Have to keep moving – if I stop, I get tired.

☐ Feeling overwhelmed by all that I need to get done

☐ It takes all my energy to do what I have to. There's none left over for anything or anyone else

Hypothyroid Quick Check

Patients Name: _____ Date: _____

Rate the Following on a scale of 0 thru 5 with 0 being not Present and 5 being Severe

1. _____ Fatigue
2. _____ Muscle Aches and Pains
3. _____ Joint Pain
4. _____ Fibromyalgia
5. _____ Feelings of Weakness
6. _____ Lethargy, or loss of interest in daily activities
7. _____ Memory Loss
8. _____ Concentration Difficulties
9. _____ Mental Sluggishness
10. _____ Low Moods
11. _____ Depressions
12. _____ Cold Hands and Feet
13. _____ Sensitivity to Cold
14. _____ Tendency towards constipation
15. _____ Weight Gain
16. _____Low blood sugar/hypoglycemia
17. _____ Menstrual Problems
18. _____ Heavy Bleeding during menses
19. _____ Repeated colds and Flu
20. _____ Skin Problems (itching, eczema, Psoriasis, acne, or coarse dry scaly skin
21. _____ Do not perspire easily
22. _____ Hoarse Voice
23. _____ Feeling of fullness in Neck
24. _____ Swelling of the eyelids
25. _____ Hair Loss
26. _____ Dry Coarse Hair
27. _____ Loss of Outer 1/3 of eyebrows
28. _____ I have as many mental and emotional symptoms as physical

Total: _____

A score of 20-40 suggests mild hypothyroidism

A score of 40-70 suggests moderate hypothyroidism

A score of anything over 70 suggest significant hypothyroid problems

General Health

100 ☐ **Fingernails base is pink**

101 ☐ **Fingernails base is purple**

102 ☐ **Fingernails are soft**

103 ☐ **Pale Fingernails have ridges/ white spots**

104 ☐ Fingernails splitting

105 ☐ Pale Fingernail peels

106 ☐ Pale fingernail beds

107 ☐ Blackout easy

108 ☐ Balance problems

109 ☐ Difficulty Walking

110 ☐ Has Tattoos

111 ☐ Brittle Hair

112 ☐ Dry Hair

113 ☐ Thin Hair

114 ☐ Hair Loss

115 ☐ Drinks alcoholic beverages daily

116 ☐ Drinks less than 8 glasses of water per day

117 ☐ Currently on Chemotherapy

118 ☐ Currently on Radiation Treatment

124 ☐ Unexplained loss > 20lbs in last 4 months

125 ☐ Energy level is worse than is was last 5 years ago

126 ☐ Sleeps less than 6 hours a night

127 ☐ Unable to recall dreams the next day

128 ☐ Sensitive to Chemicals, paints, fumes, cologne

129 ☐ Had blood transfusion in past

130 ☐ Had transplant in past

131 ☐ Take anti-rejected drugs

132 ☐ Had major Accident or injury

133 ☐ Sleep Apnea

134 ☐ Toxic Chemical Exposure

135 ☐ Has been out of Country recently

136 ☐ Has Childhood Vaccines

137 ☐ Had Vaccines in last 12 months

138 ☐ Had a Flu Shot last year

139 ☐ Had pneumonia Shot Last Year

140 ☐ Had Hepatitis B Vaccine in last 2 years

Has A Family History of:

☐ **Cancer**

Do you use? ☐ Well Water ☐ City Water Filters? ☐ Yes ☐ No

Filter Type: _____

1. What Type of Pipes are in your home?
   ☐ **Steel** ☐ **CPVC** ☐ **Copper** ☐ **Pex** ☐ **Other** _____
2. Do you use Chlorine bleach or other heavy-duty cleaning in your home/office? ☐ **Yes** ☐ **No**
3. Have you ever worked around heavy machinery, plumbing, automotive or Metallurgic Industry? ☐ **Yes** ☐
   Explain: _____
4. Have you ever worked around industrial solvents, chemicals, pesticides?
   ☐ **Yes** ☐ **No** Explain: _____

Lifestyles & Environment

☐ Drink Beverages from a can ☐ Drinks > 1 pop/soda per day ☐ I had 4 alcoholic drinks in one day

☐ Drink alcohol - I had 4 alcoholic drinks in one day ☐ Regularly Exercises

☐ Drink Caffeinated Coffee ☐ Never ☐ Take Vitamins

☐ Drink Caffeinated pop/soda ☐ More than 3 months ago ☐ Vegetarian

☐ Drink Caffeinated Tea ☐ Less than 3 months ago ☐ Eat No Red Meats

☐ Drink Decaffeinated Coffee ☐ Had > 5 Alcoholic drinks/week ☐ Eats No Meats/Dairy

☐ Drinks Decaffeinated Pops/Soda ☐ Crave Sugar/Starches ☐ Frequently use Artificial Sweetener

☐ Drink Decaffeinated Tea ☐ Currently Smokes ☐ Anorexia

☐ Drinks >3 Cups of Coffee Daily ☐ Quit Smoking in last 5 years ☐ Bulimic

☐ Drinks >3 cups of tea per day ☐ Smoked for >5 years

☐ Drinks Diet Pop/Soda ☐ Smokes > 1 pack per day

Behavior Patterns

☐ Afraid to eat anywhere but home ☐ Often Annoyed by People

☐ Always need someone's Advice ☐ Recurrent Bad Dreams

☐ Cries Often ☐ Sometimes wish to be dead or away from it all

☐ Difficulty Concentrating ☐ Upset by Criticism

☐ Difficulty Falling Asleep ☐ Poor Memory

☐ Difficulty Staying Asleep ☐ Scared to be Alone

☐ Easily Angered ☐ Strange People or Places Cause Fear

☐ Feelings are Easily Hurt ☐ Under Considerable Emotional Stress

☐ Frequently Become Scared for No Reason ☐ Unhappy when Others are Happy

☐ Frequently Miserable or Blue ☐ Brain Fog

☐ Has to be on Guard even with Friends

Urinary

- ☐ Urinate more than 2 times per night
- ☐ Trouble by Urgent Urination
- ☐ Bed Wetting
- ☐ Incontinence when Sneezing/Laughing
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Difficulty Starting to Urination
- ☐ Frequent Bladder Infections
- ☐ Painful Urination
- ☐ Frequent Kidney Infections
- ☐ Frequent Urination
- ☐ Kidney Stones

Men Only

- ☐ Difficulty Completing Intercourse
- ☐ Painful Genitals
- ☐ Difficulty Getting/Keeping an Erection
- ☐ Prostate Troubles
- ☐ Discharge from Urethra
- ☐ Sore on External Genitalia
- ☐ Had Difficulty Fathering Children
- ☐ Herpes
- ☐ Had a Vasectomy
- ☐ Sexual Disease
- ☐ Lumps in the Testicles

Women Only

- ☐ Heavy Hair Growth on the Face/Body
- ☐ Lump in the Breast
- ☐ Cycles every 27-29 days
- ☐ Abdominal Cycle > 29 days and/<26 Days
- ☐ Tender Breast
- ☐ Vaginal Discharge
- ☐ Bloody Spotting Discharge
- ☐ PMS
- ☐ Tender Breast
- ☐ Menstrual Cramping
- ☐ Yeast Infections
- ☐ Painful Periods
- ☐ Sore or External Genitalia
- ☐ Acne Worse at Menstruation
- ☐ Herpes
- ☐ Excessive Menstrual Flow
- ☐ Sexual Diseases
- ☐ Endometriosis
- ☐ Retained Fluids during Period
- ☐ Breast Reduction
- ☐ Breast Augmentation

Women Only Continues:

☐ Pre-Menstrual Depression ☐ Abortion ☐ D&C

☐ Taken Birth control more than a year ☐ Tubal Pregnancy ☐ Uterine Fibroids

☐ Taken Birth control within the last year ☐ Hot flashes ☐ Has Had Miscarriage

☐ Ovarian Fibroids Painful Intercourse ☐ Breast Fibroids ☐ Poor/infrequent orgasm

☐ Currently Breastfeeding

Endocrine

☐ Course Hair ☐ Frequently feeling Cold ☐ Unusually Jumpy/nervous

☐ Coarse Skin ☐ Frequently feel Hot ☐ Unusually tired most of time

☐ Diabetic ☐ Get Light headed when standing

☐ Excessive Thirst ☐ Heal Slowly

Cardiovascular

☐ Cold Feet ☐ Pain in leg/Hips when Walking

☐ Cold Hands ☐ Pain in the Heart/Chest

☐ Heart skips beats ☐ Spells of Rapid Heart Rate

☐ Experiences of shortness of breath while sitting still ☐ Heart Palpitations

☐ Tendency of High Blood Pressure ☐ Unusual slow pulse rate

☐ Trouble with Blood Clots ☐ Leg Cramping during Bedtime

☐ Leg Cramping during the day ☐ Varicose Veins

☐ Low Blood pressure at times ☐ Frequent Swollen Ankles

Skin

☐ Bruise Easily ☐ Itchy Skin ☐ Skin Eruptions

☐ Excessive Perspiration ☐ Problem with Eczema ☐ Skin is Tender

☐ Frequent goose bump ☐ Varicose Veins ☐ Sores that heal slowly

☐ Has Acne ☐ Has moles which are changing in size/color ☐ Trouble with Boils

☐ Has Psoriasis ☐ Skin is Rough, especially on the back of arms ☐ Dry Skin

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Ears

☐ Discharge from ears ☐ Punctures ear drums ☐ Ringing/Noise in the ears

☐ Hard of Hearing ☐ Recurrent Ear Infection ☐ Tinnitus

Eyes

☐ Bloodshot eyes ☐ Eyes Watery ☐ Mild Macular Degeneration

☐ Blurred Vision ☐ Mild Glaucoma ☐ Itchy Eyes

☐ Cross Eyes ☐ Far Sighted ☐ Near Sighted

☐ Eye Pain ☐ Developing Cataracts ☐ Dry Eyes

☐ Eyes feel Gritty

Feet

☐ Corns ☐ Painful Feet ☐ Swelling in feet/Ankles

☐ Frequent Foot Crams ☐ Plantar Warts ☐ Plantar Fasciitis

☐ Heel Spurs ☐ Fungal Infections

Neuromuscular

- ☐ Bites Nails
- ☐ Frequent Muscle Soreness
- ☐ Muscle Spasms
- ☐ Muscle Weakness
- ☐ Tremors
- ☐ Often Dizzy
- ☐ Frequently feel Faint
- ☐ Has Epilepsy
- ☐ has Motion Sickness
- ☐ Has Osteoarthritis
- ☐ Has Rheumatism
- ☐ Rheumatoid Arthritis
- ☐ Joint Stiffness in the Am
- ☐ Swollen Joints
- ☐ Leg Pain at Rest
- ☐ Spinal Curvature
- ☐ Low back pain
- ☐ Neck Pain
- ☐ Pain between Shoulders
- ☐ Shoulder/Arm Pain
- ☐ Numbness/Tingling in Body
- ☐ Stutters or Stammers
- ☐ Nerve Pain

Surgeries

- ☐ Tonsillectomy and/or Adenoids
- ☐ Appendix
- ☐ Gallbladder
- ☐ Thyroid
- ☐ Hysterectomy Complete
- ☐ Hysterectomy Partial
- ☐ Tubal Ligation
- ☐ Breast Implants
- ☐ Cancer
- ☐ Coronary Bypass
- ☐ Spinal Surgery
- ☐ Extremity Surgery
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Splenectomy
- ☐ Radiated Thyroid
- ☐ Cataract Surgery
- ☐ Hemorrhoidectomy
- ☐ Bariatric/Weight loss

Type: _____

Gastrointestinal

- ☐ 4-5 Bowel Movements per Week
- ☐ 3 or Less Bowel Movements per week
- ☐ 6 or More Bowel Movements per week
- ☐ Black Tarry Stool
- ☐ Constipation
- ☐ Blood stools
- ☐ Hemorrhoids
- ☐ Loose Bowel Movements
- ☐ Frequent Diarrhea
- ☐ Frequent Nausea
- ☐ Frequent Vomiting
- ☐ Abdominal Gas
- ☐ Belching and Burping after Eating
- ☐ Bloated after eating
- ☐ Severe Abdominal Pain
- ☐ Stomach Ulcers
- ☐ Uses Digestive Aids
- ☐ Uses Laxatives
- ☐ Immediate Indigestion upon Eating
- ☐ Indigestion in 2 Hours or more after meals
- ☐ Indigestion within 1 hour after meals
- ☐ Difficulty Swallowing
- ☐ Eating Relieves Fatigue
- ☐ Eating When Nervous
- ☐ Excessive Hunger
- ☐ Poor Appetite
- ☐ Experiences Fainting Spells when Hungry
- ☐ Feeling Shaky when Hungry
- ☐ Frequently Drowsy after eating a meal
- ☐ Gall Bladder Disease
- ☐ Has Had Intestinal Worms
- ☐ Reflux/Hiatal Hernia
- ☐ Liver Disease
- ☐ Irritable Bowel Syndrome
- ☐ Diverticulitis
- ☐ Diverticulosis

Respiratory

- ☐ Catches Severe Colds
- ☐ Chronic Chest Condition
- ☐ Chronic Cough
- ☐ Constant Runny Nose
- ☐ COPD
- ☐ Difficulty Breathing
- ☐ Frequent Colds
- ☐ Frequent Nose Bleeds
- ☐ Frequent Sinus Infections
- ☐ Frequent Stuffy Nose
- ☐ Hay Fever
- ☐ Nasal Polyps
- ☐ Night Sweats
- ☐ Post Nasal Drip
- ☐ Sneezing Spells
- ☐ Spits up Blood
- ☐ Spits up Phlegm
- ☐ Wheezes

Mouth & Throat

- ☐ Bad Breath
- ☐ Bitter taste in mouth In morning
- ☐ Dry Mouth
- ☐ Excessive Saliva
- ☐ Sores or cracks in corner of mouth
- ☐ Glands often Swollen
- ☐ Frequent Canker Sores
- ☐ Frequent Fever Blisters
- ☐ Frequent sore Throats
- ☐ Frequently has sore Tongue
- ☐ Sore Gums
- ☐ Swollen Gums
- ☐ Swollen Tongue
- ☐ Tongue Burns
- ☐ Tongue has Grooves or Fissures
- ☐ Tongue is Coated
- ☐ Gums bleed when Brushing teeth
- ☐ Amalgam Dental Fillings
- ☐ Other Dental Fillings (gold, Composite, etc.)
- ☐ Has Had Root Canals
- ☐ Toothaches