## NEW CLIENT APPLICATION and CONSENT

*Welcome! Thank you for choosing **Balancing Your Health** for your natural health care needs.*
*We realize that these forms are rather extensive, but it is extremely important for you to answer every question completely before returning them. Your cooperation will help us help you. Thank you!*

Name: ______________________________________________________Today's Date:____________________

E-mail address: _________________________ _______________ Occupation: __________________________

Address: ______________________________________________ City, State, Zip: _______________________

Phone: (Home) (_____)________________ (Office) (_____)________________ (Cell) (_____)________________

Birthdate: ____________ Marital Status (please circle one): M S D W Number of children: Boys ____ Girls ____

Current Dietary Status (please check all that apply):

_____ Vegetarian _____ Typical U.S. Fare ____ Blood Type Diet ____ South Beach ____ Other, please describe
_____ Macrobiotics _____ Junk Food Junkie ____ Weight Watchers ____ Low Carb ___________________________
_____ Organic _____ Chocoholic ☺ ____ Zone Diet ____ Makers Diet ___________________________

Current Lifestyle Challenges (please check all that apply): How much/how often do you indulge/participate in the following:

_______Alcohol _______ Recreational Drugs _______ Tobacco _______ Prescription Drugs _______Coffee _______Colas _______ Tea

Exercise, what kind? ______________________________________________________________________
I typically eat _________ times per day. I usually have __________ bowel movements per _______________ . (write Day or Week)
Blood Type _________ Height __________ Weight __________ Are you pregnant? __________ If yes, how many months?_________

Sleep: (Circle all answers that apply.)

How long does it take to fall asleep? 0-5 min 5-15 min 15-30 min 30-60 min 60+ min
How long do you sleep? I do not wake up until morning. I wake once and resume sleep quickly. I wake more than once. I sleep well at first, then fitfully. I awaken at 3 or 4 AM and am unable to get back to sleep.
How do you feel in the morning? I feel great. I get up easily, but tired. I get up slowly. It is difficult to wake in the morning.
When are you hungry? Within half an hour after waking. Within 2 hours after waking. By lunch time. By supper time.
Do you dream? Occasionally Long, detailed dreams Disturbed dreams
Miscellaneous: Do you snore? _________ Do you sleep with someone who snores? _________ Do you stop breathing when you sleep?________
Do your limbs jerk or move erratically when you sleep? _________ Do you grind your teeth? _________ Do you have night sweats? _________

Referred by:

___________________________________________________________________________________________

***CLIENT STATEMENT***

*I understand that my health is my responsibility and I am here to learn about nutrition and better health practices. I will be offered information about food supplements, oils, homeopathics, frequencies, and herbs as a guide to general good health. This is considered a personal ministry of natural health care and I have requested this information. Whether or not I ultimately choose this route to good health is strictly my decision. I understand that those who counsel me are not medical doctors or practitioners and I am not here for medical-diagnostic purposes or treatment procedures. I am not, on this visit or any subsequent visit, an agent for any federal, state, church, or local agencies, or on a mission of entrapment or investigation. The services performed in/by this office are at all times restricted to consultation on the subject of nutritional matters intended for my education and the maintenance of the best possible state of nutritional health and do not involve the diagnosing, treatment or prescribing of medications for disease.*

Signature: ______________________________________________________ Date: ________________________________

1. Please list any aches, pains, inflammation, dislocations, abnormalities or traffic/major accidents that your body may have endured.

2. Please list any surgeries or additions to your original body. GRIN! (Ex: pacemakers, joint replacements, organ transplants, rods or pins, etc.)

3. Please list all medications (prescribed and/or over the counter) you currently use:

| Medication | Purpose |
|---|---|
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4. Please list all supplements you currently use on a regular basis:

| Supplement | Purpose |
|---|---|
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# Personal History

(Please write ***O*** if you experience this complaint *O*ccasionally, ***F*** if you have this complaint *F*requently, ***C*** if you have this complaint *C*onstantly)

**General/Constitutional**

___ Allergies
___ Chills/Fever
___ Convulsions/Seizures
___ Dizziness/Fainting
___ Insomnia
___ Weight loss/gain
___ Depression

**Nerves/Brain**

___ Memory Loss
___ Nervousness
___ Stress
___ Tingling/Tremors
___ Numbness
___ Pain
___ Headaches

**Muscle/Joint/Skeletal**

___ Ligaments/Tendons
___ Poor posture
___ Sciatica
___ Spinal curvature
___ Swollen/painful joints

*Pain/numbness in:*

___ Neck
___ Between Shoulders
___ Shoulders
___ Arms
___ Elbows
___ Hands/Fingers
___ Low back
___ Hips
___ Tailbone
___ Legs
___ Knees
___ Feet/toes

**Digestive/Intestinal**

___ Belching/Gas
___ Colon problems
___ Constipation
___ Diarrhea
___ Heart burn/indigestion
___ Acid reflux
___ Swollen Abdomen
___ Excessive hunger
___ Poor appetite
___ Gallbladder problems
___ Nausea/Vomiting
___ Stomach pains
___ Liver problems
___ Jaundice
___ Hemorrhoids
___ Parasites

**Lungs**

___ Chronic infections
___ Cough
___ Difficulty breathing
___ Wheezing
___ Spitting up blood
___ Chest pain

**Eyes, Ears, Nose, Throat**

___ Chronic infections
___ Sinus problems
___ Hoarseness
___ Coated tongue
___ Colds
___ Allergies
___ Earache
___ Ears ringing
___ Ear discharge/itching
___ Deafness
___ Swollen/painful tonsils
___ Nose bleeds
___ Gum problems
___ Failing vision
___ Eye pain
___ Eyelid pain/discharge

**Vascular/Cardio-Vascular**

___ Hardening of arteries
___ High blood pressure
___ Low blood pressure
___ Chest pain/over heart
___ Poor circulation
___ Rapid/irregular heart beat
___ Swollen ankles
___ Artery sludge/plaque
___ Varicose veins
___ Fragile capillaries

**Skin and Nails**

___ Boils
___ Bruising
___ Dryness
___ Hives
___ Itching
___ Skin eruptions
___ Lumps/abnormal growths
___ Moles/warts
___ Nail Fungus
___ Nails brittle/thin/splitting

**Lymph/Blood**

___ Swollen/painful lymph nodes
___ Low iron
___ Thick blood
___ Free bleeder

**Kidney/Bladder/Prostate**

___ Chronic infections
___ Bed wetting
___ Blood in urine
___ Water retention
___ Frequent urination
___ Painful/difficult urination
___ Dribbling urination
___ Incontinence
___ Prostate problems

**Endocrine**

___ Thyroid problems

Female

___ Painful menses
___ Cramps
___ Heavy menstrual flow
___ Hot flashes
___ Irregular cycle
___ Vaginal itching/discharge
___ Painful/lumpy breasts
___ Low libido
___ Mood changes

Male

___ Loss of muscle tone
___ Low libido
___ Excessive anger
___ Mood changes

***Please check*** any of the following conditions you have had:

___ Abortion
___ Alcoholism
___ Appendicitis
___ Arteriosclerosis
___ Cancer
___ Cold sores
___ Diptheria
___ Emphysema
___ Fever Blisters
___ Goiter
___ Heart Disease
___ Herpes
___ Influenza
___ Measles/Mumps
___ Psoriasis
___ Stroke
___ Tuberculosis
___ Venereal Disease
___ Acid Reflux
___ ADD/ADHD
___ Arthritis
___ Bursitis
___ Chorea
___ Diabetes
___ Eczema
___ Epilepsy
___ GERD
___ Gout
___ Hernia
___ HIV/AIDS
___ Miscarriage
___ Polio
___ R. Arthritis
___ Scarlet Fever
___ Ulcers
___ Whooping Cough
___ Other ______________________________

______________________________