

First Name:	Last Name:	Date of Birth:
Prefer to be Called:	Marital Status (Circle): Single Married Partnered Widowed Separated	Age:
Street Address:	City:	State: Zip:
Preferred Phone (Circle): home work cell	Alternate Phone: home work cell	May we leave a message on your preferred phone? <input type="radio"/> Yes <input type="radio"/> No
Employer:	Occupation:	SS#
Emergency Contact Name:	Preferred email:	Primary Care Physician:
Emergency Phone(s):		
List any drug allergies:	Preferred Pharmacy:	List any food allergies:

What is your main reason for your visit today?

Which Services Interest You:

- | | | |
|--|---|--|
| <input type="radio"/> acupuncture | <input type="radio"/> energy medicine | <input type="radio"/> men's health |
| <input type="radio"/> aromatherapy | <input type="radio"/> emotional freedom technique | <input type="radio"/> nutritional testing |
| <input type="radio"/> Biofeedback | <input type="radio"/> frequency specific microcurrent | <input type="radio"/> metabolic blueprint |
| <input type="radio"/> bio-identical hormones | <input type="radio"/> functional medicine | <input type="radio"/> nutrition counseling |
| <input type="radio"/> Bowen technique | <input type="radio"/> food allergies testing | <input type="radio"/> organization |
| <input type="radio"/> Chiropractic | <input type="radio"/> health coaching | <input type="radio"/> rapid eye technology |
| <input type="radio"/> craniosacral therapy | <input type="radio"/> Healing Touch™ | <input type="radio"/> Reiki |
| <input type="radio"/> counseling/therapy | <input type="radio"/> HeartMath™ | <input type="radio"/> walk & talk therapy |
| <input type="radio"/> detox program | <input type="radio"/> life coaching | <input type="radio"/> wellness |
| <input type="radio"/> energy medicine | <input type="radio"/> massage | <input type="radio"/> weight loss |

Would you like to receive our newsletter?

Yes No (we will never sell your name)

Cancellation & Re-Scheduling Policy

We understand that there are times when you will need to cancel and/or reschedule your appointment due to emergencies. We will do our best to accommodate your needs in such situations.

Please know that all cancellations and/or rescheduling requests must be made at least two business days prior to the date of your appointment. If a previously scheduled session is not cancelled or rescheduled within 24 hours of the time of the appointment, that session will be "missed" and charged for the full session fee. Thank you for your understanding.

() I understand and accept this policy

Your Signature

Today's Date

Records and Privacy Policy: We will not release your records to anyone without your written consent. Because this is an integrated practice with multiple practitioners, we may facilitate care by having only one record per client. Coordinated care by your chosen practitioners will always be done with respect for your personal privacy and confidentiality.

() I understand and accept this policy

Your Signature

Today's Date

Name: _____

DOB: _____

Do You Exercise? What Type? How Often Per Week? For How Long?	Daily Stress Level (Please Rate) <input type="radio"/> High <input type="radio"/> Moderately High <input type="radio"/> Average <input type="radio"/> None	Daily Energy Level (Please Rate) <input type="radio"/> Excellent <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor																								
How Important is Religion/Spirituality to You and Your Family's Life? <input type="radio"/> Extremely Important <input type="radio"/> Somewhat Important <input type="radio"/> Not At All Important	How Well Do You Sleep? How Long Do You Sleep?	Do You Drink Alcohol? How Much Per Week?																								
Do You Use Recreational Drugs? How Much Per Week?	Do You Smoke? How Much Per Day? For How Many Years?	Where have you lived and traveled?																								
Previous Surgery and Dates: <input type="radio"/> Appendectomy <input type="radio"/> Hysterectomy <input type="radio"/> Tonsils/Adenoids <input type="radio"/> Breast biopsy <input type="radio"/> Back surgery <input type="radio"/> Knee surgery <input type="radio"/> Oral surgery <input type="radio"/> Cesarean Section <input type="radio"/> Tubal Ligation/Vasectomy <input type="radio"/> Other: <input type="radio"/> Other: <input type="radio"/> Other: Previous Injuries and Dates: <input type="radio"/> Head Injury _____ <input type="radio"/> Neck injury _____ <input type="radio"/> Back injury _____ <input type="radio"/> Bones Broken: _____ Previous Car or Tramatic Injury: <input type="radio"/> Head Injury <input type="radio"/> Neck injury <input type="radio"/> Back injury <input type="radio"/> Bones Broken:	Have You Been Diagnosed With: <input type="radio"/> Anemia <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Bronchitis <input type="radio"/> Cancer type: _____ <input type="radio"/> Diabetes <input type="radio"/> Epilepsy <input type="radio"/> Gallstones <input type="radio"/> Gout <input type="radio"/> Heart Attack <input type="radio"/> Heart Failure <input type="radio"/> Heart Valve Problems <input type="radio"/> Hepatitis (Liver problem) <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol or Triglycerides <input type="radio"/> Irritable Bowel or Colitis <input type="radio"/> Kidney Stones <input type="radio"/> Mononucleosis <input type="radio"/> Plantar Fasciitis <input type="radio"/> Pneumonia <input type="radio"/> Rheumatic Fever <input type="radio"/> Sleep Apnea <input type="radio"/> Stroke <input type="radio"/> Thyroid Problems	Do You Have or Wear: <input type="radio"/> Glasses <input type="radio"/> Contact lenses <input type="radio"/> Hearing Aid(s) <input type="radio"/> Dentures <input type="radio"/> Pacemaker <input type="radio"/> Artificial knee(s) <input type="radio"/> Artificial hip(s) <input type="radio"/> Other: How Often Have You Taken Antibiotics? <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;"><u><5 times</u></td> <td style="text-align: center;"><u>>5times</u></td> </tr> <tr> <td>Infancy/Childhood</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Teen</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Adult</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table> How Often Have You Taken a Course of Oral Steroids? <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;"><u><5 times</u></td> <td style="text-align: center;"><u>>5times</u></td> </tr> <tr> <td>Infancy/Childhood</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Teen</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Adult</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>		<u><5 times</u>	<u>>5times</u>	Infancy/Childhood	<input type="radio"/>	<input type="radio"/>	Teen	<input type="radio"/>	<input type="radio"/>	Adult	<input type="radio"/>	<input type="radio"/>		<u><5 times</u>	<u>>5times</u>	Infancy/Childhood	<input type="radio"/>	<input type="radio"/>	Teen	<input type="radio"/>	<input type="radio"/>	Adult	<input type="radio"/>	<input type="radio"/>
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Adult	<input type="radio"/>	<input type="radio"/>																								

Any Other Hospitalizations and Dates:

With whom do you live?

Have you or your family recently experienced any major life changes? If yes, please explain.

NAME: _____

DOB: _____

What percentage of the food you eat is home cooked? _____%

How often do you have bowel movements?

- more than 3 times a day 1-3 times a day 4-6 times a week 1-3 times a week

Which if any of these features describe your bowel movements?

- soft hard float sink offensive odor blood visible difficult to pass watery

Please list what you usually eat for:

Breakfast

Mid Morning Snack

Lunch

Afternoon Snack

Dinner

Desserts

Have you found certain foods do not "agree with you" or cause symptoms? If so, please identify the food and symptom you have.

How well have things been going for you?

	Very Well	Fair	Poor	Very Poor	Does Not Apply
With your attitude					
In your job					
At school					
In your social life					
With your close friends					
With your spouse					
With your boyfriend/girlfriend					
With your parents					
With your children					
With sex					

NAME: _____

DOB: _____

Family History: Please briefly describe any problems affecting your family below. If deceased, provide cause of death and their approximate age.

Mother – _____

Father – _____

Mother's Mother - _____

Mother's Father – _____

Father's Mother – _____

Father's Father – _____

Sibling(s) – _____

Spouse/Significant Other – _____

Child/Children – _____

Mother's Siblings – _____

Father's Siblings - _____

Ob-Gyn History (Women Only)

Number of pregnancies total:

Number of miscarriages:

Number of abortions:

Current method of contraception:

Date of last pap smear:

Date of last mammogram/thermogram:

Review of Symptoms: Please check if these symptoms occur presently or have occurred in the past 6 months. Note if the symptom is not applicable (n/a), mild, moderate or severe and add comments if indicated.

CATEGORY	SYMPTOM	SEVERITY							COMMENTS	
GENERAL	Cold hands/feet	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Cold intolerance	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Daytime sleepiness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty falling asleep	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Waking early	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fatigue	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Flushing	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heat intolerance	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Night waking	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Nightmares	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	No dream recall	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Distorted sense of smell	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Distorted sense of taste	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Ear ringing/buzzing	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Eye crusting	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Eye pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Headache/migraines	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Hearing loss	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vision problems	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	

NAME: _____

DOB: _____

CATEGORY	SYMPTOM	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	COMMENTS	
MUSCLE	Calf cramps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Chest tightness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Foot cramps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Joint deformity	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Joint pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Joint redness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Joint stiffness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Muscle pain/spasms	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Muscle twitches: eyes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Muscle twitch: arms/legs?	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Muscle weakness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Tendonitis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Tension headaches	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	TMJ	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	MOOD	Anxiety	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
		Depression	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
		Difficulty concentrating	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
		Difficulty with balance	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
Difficulty with thinking		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Difficulty with judgment		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Difficulty with speech		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Difficulty with memory		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Dizziness		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Fainting/light headed		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Fearfulness		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Irritability		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Numbness		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Phobias		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Paranoia		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Seizures		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Suicidal thoughts		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Eating		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Bulimia		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Can't gain weight		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Can't lose weight		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
Carbohydrate craving	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe			
Poor appetite	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe			
Salt craving	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe			
DIGESTION	Bleeding gums	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Bloating in abdomen	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Blood/mucous in stool	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		
	Burping/flatulence	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe		

NAME: _____

DOB: _____

CATEGORY	SYMPTOM	SEVERITY							COMMENTS	
		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>		severe
	Canker sores	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Cold sores	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Constipation	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Diarrhea	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Difficulty swallowing	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Dry mouth	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Foods repeat(reflux)	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heartburn	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Hemorrhoids	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Liver disease/jaundice	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Nausea	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Periodontal (gum) disease	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Strong stool odor	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Undigested food in stools	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vomiting	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
SKIN	Acne on face	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Athlete's foot	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Bumps - back upper arm	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Cellulite	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Dark circles under eyes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Easy bruising	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Eczema	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Herpes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Hives	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Oily skin	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Psoriasis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Rash	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Shingles	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Skin cancer	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Strong body odor	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vitiligo	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Dryness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Enlarged lymph nodes	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fingernails bitten	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fingernails brittle	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fungus fingernails/toenails	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	White spots fingernails	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
RESPIRATORY	Sleep Apnea	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Nose bleeds	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Post nasal drip	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Sinus infections	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Snoring	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	

NAME: _____

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CATEGORY	SYMPTOM	SEVERITY						COMMENTS		
		<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate		<input type="radio"/>	severe
	Breathlessness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
HEART	Heart attack	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heart murmur	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	High blood pressure	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Irregular pulse	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Mitral valve prolapse	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Palpitations	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Phlebitis/blood clots	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Swollen ankles/feet	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Varicose veins	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Infection	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
URINARY	Kidney disease	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Kidney stone	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Leaking/incontinence	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Pain/burning	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Urgency	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Prostate infection	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
MALES	Discharge from penis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Ejaculation problem	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Genital pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Lumps in testicles	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Low libido (sex drive)	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Breast lumps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
FEMALES	Breast tenderness	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Ovarian cyst	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Low libido (sex drive)	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Endometriosis	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Fibroids	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Infertility	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal discharge	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal odor	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal itch	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Vaginal pain	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	PMS symptoms	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Menstrual cramps	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Heavy periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Irregular periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	No periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	
	Spotting between periods	<input type="radio"/>	n/a	<input type="radio"/>	mild	<input type="radio"/>	moderate	<input type="radio"/>	severe	

LIVING WELL

: health & wellness center :

LEGAL WAIVER

I am attending this nutritional consultation and working with Living Well Dallas (LWD) of my own volition. LWD recommends that you inform your medical doctor of any and all dietary changes which you make as a result of her recommendations.

I understand that the person teaching and leading this session is a health & nutrition coach and is not a doctor or registered dietician. I take full responsibility for my health and for the decisions regarding my diet that I make as a result of their recommendations.

I understand that LWD is trained to help guide clients regarding the improvement of their health through dietary and lifestyle changes. Any dietary supplements that are recommended are suggestions and whether or not I partake of these suggestions is as a result of my own volition.

I hereby release and discharge Living Well Dallas, Inc. from any and all claims that I or my family or heirs, have or may have, now or in the future. I have read and understood all of the above, and agree to proceed under these conditions.

I understand that the above is meant to have legal significance and be legally binding.

Print Full Name

Patient Signature

Date