# Individual Health Information Sheet

Name: _____ Phone: _____

Address: _____ Birth Date: _____

City: _____ Mobile: _____

State/Zip: _____ Email: _____

List top 3 symptoms you would like relief from (see symptom sheet):

_____

Health Goals:

_____

How much sweaty activity weekly? _____ What type?: _____

How many ounces of water daily? _____ What type?: RO Tap Spring Distilled Filtered

Which meals do you eat? Breakfast Lunch Dinner Snacks How many bowel movements daily? _____

Do you take digestive enzymes? Yes No Breathing exercises? Yes No Blood Type: A B AB O

How much of the following do you consume? Example – 1D = once daily, 3M = 3 times monthly

Soda: _____ Coffee: _____ Smoking: _____ Alcohol: _____
Milk: _____ Fast Food: _____ Sugar: _____ White Flour: _____
Meat: _____ Raw Fruit: _____ Raw Veg: _____ Whole Grain: _____

What foods do you crave? Salty Chocolate Sweets Breads Other: _____

What are your favorite foods? _____

Rate your daily energy: (1 = lowest energy level; 10 = highest energy level): _____
List any surgeries you've had. Circle NONE if applicable:

_____

How many hours of screen time do you have daily/weekly? D: _____ W: _____

Amount of spiritual activity daily/weekly (Bible, prayer, church, etc)? D: _____ W: _____

How much time do you spend with family/friends? D: _____ W: _____

How much sleep do you get each night? _____ How much do you need? _____

List prescription meds you are taking:

_____

List supplements you take:

_____

Would you like to be contacted with periodic updates? YES NO

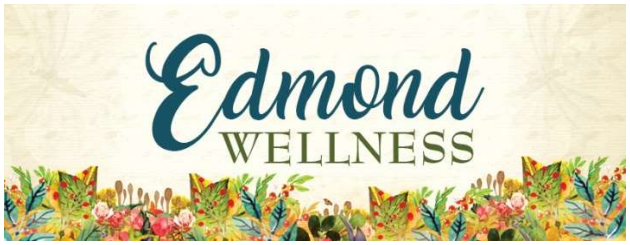
Who referred you for your appointment today? _____

I understand that I am here to learn about nutrition and better health practices and that I will be offered information about food supplements and herbs as a guide to general good health and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors 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 federal, state, or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation or nutritional matters intended for the maintenance of the best possible state of natural health and do not involve the diagnosing, treatment or prescribing of remedies for disease.

Signature: _____ Date: _____/_____/_____

## Symptoms and Areas of Concern

Acne
ADD/ADHD
Adrenal Glands
Allergies
Alzheimer's Disease
Anemia
Anger
Anxiety
Appetite
Arteriosclerosis
Arthritis
Asthma
Back Pain
Bad Breath
Bed Wetting
Bell's Palsy
Bites
Bladder
Blood Pressure (High)
Blood Pressure (Low)
Boils
Bones
Breathing
Bronchitis
Bruises
Burns
Cancer
Candida
Canker Sores
Carpal Tunnel
Cataracts
Chest Congestion
Chest Pain
Cholesterol
Circulation
Colds – Common
Cold – Temperature
Colic
Colon
Constipation
Cough
Cravings
Dandruff
Depression
Diabetes
Diarrhea
Digestion
Dizzy Spells
Ear Infection
Ear Ringing
Edema
Emphysema
Epilepsy
Eyesight
Fatigue
Fever
Flu
Gallstones
Gangrene
Gas
Gout
Gums
Hair Issues
Headache
Heart Issues
Heartburn
Herpes
Hemorrhoids
Hiatal Hernia
Hives
Hormones
Hyperactive
Hypertension
Hyperthyroidism
Hypoglycemia
Impotence
Incontinence
Indigestion
Insomnia
Joint Pain
Kidney Issues
Kidney Stones
Laryngitis
Leprosy
Leukemia
Liver
Lung Issues
Lupus
Lymph Glands
Menopause
Menstrual Cramps
Migraines
Mononucleosis
Mucous
Nails
Nausea
Nervousness
Nose bleeds
Parasites
Parkinson's Disease
Perspiration
PMS
Pneumonia
Polyps
Pregnancy
Prostate
Psoriasis
Rash
Reproduction
Respiratory
Rheumatism
Ring Worm
Seizure
Shingles
Sinus
Skin Issues
Snoring
Sore Throat
Stomach
Stress
Stroke
Sty
Teething
Tennis Elbow
Tonsillitis
Tumors
Ulcers
Urinary Infections
Varicose Veins
Vertigo
Weight – Over
Weight – Under
Yeast Infections
OTHER: _____




# APPOINTMENT CANCELATION & REFUND POLICY

Clients,

We strive to provide excellent care for you and our other clients. In order to do so effectively and efficiently, we have developed an appointment schedule that sets aside ample time for the client.

"No-shows" and cancellations inconvenience those individuals who need access to our services in a timely manner. In an effort to reduce the number of such occurrences, we have implemented an Appointment Cancelation Policy and it is effective immediately.

Our cancelation policy is as follows:

1. We request you give our office 24-hour notice in the event that you need to reschedule your appointment. Our office number is (405)757-4370. You may call or text this number.
2. If you reschedule or miss an appointment without contacting us with at least 24-hour prior notice, we will consider this a missed appointment and your session has been forfeited. If this missed appointment is for a "Try Your First Session for $40" special, that discounted price will be forfeited.
3. If you are late to your appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length or rescheduled.
4. Our office makes efforts to ensure your awareness of the appointment times you choose via text and email notifications. ***It is ultimately the client's responsibility to remember their scheduled appointment time.***

Our refund policy is as follows:

1. Per Groupon policy, all Groupon refunds must be initiated by the consumer at groupon.com/support. We are unable to initiate a refund on Groupon purchases.
2. Refunds are not available for services rendered.
3. Partial refunds will be issued for unused services when a cancelation and refund is requested more than 24 hours prior to the next scheduled appointment.

We thank you for trusting Dr. Holly Moulder, Naturopath and Edmond Wellness for your wellness and weight loss care.

***I have read and understand these policies and agree to their terms.***

_____ _____

Signature Date

_____ _____

Printed Name Witness Initials