

## 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

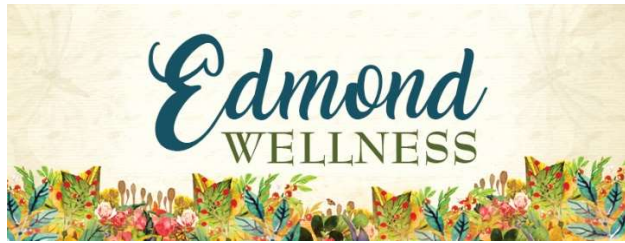
Who referred you for your appointment today? \_\_\_\_\_

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



## **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 Cancellation Policy and it is effective immediately.

Our cancellation 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](http://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 cancellation 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