4155 E. Jewell Ave, Suite 801
Denver, CO 80222
(303) 504-0772

Name____

Street____________________________________Apt. #____________

City________________________State_____________Zip____________

Phone: (H)_____________(W)_____________(Cell)_________________

Email______________________________Birthdate_________________

Age ________Marital Status__________Children (Y/N)?_____________

Employer Name ____

Employer Address____

Physician___________________________Date of last physical_________

Emergency Contact __________________________Phone #______________

Relationship _________________________

Referred by ____

Payment is Due In Full at the time of service. Acacia Whole Health does not bill Health Insurance Companies or write letters for Health Flex Plans.

INITIAL CONSULTATION*:

Rennetta Nikolic - $395.00 Traditional Naturopath
Stefan Nikolic - $365.00 Certified Nutrition Therapist
Casey Docksey - $345.00 Certified Holistic Health Practitioner

OTHER SERVICES (Cost/Session):

Frequency Generator - $59.00
Ion Cleanse - $50.00

ALL FOLLOW-UP VISITS*:

Rennetta:	Stefan:	Casey:
30 Minutes - $115.00	$95.00	$75.00
45 Minutes - $165.00	$145.00	$125.00
60 Minutes - $195.00	$175.00	$155.00

**Above rates do not include Generator Sessions, Ion Cleanse Sessions, or Supplements.*

Please Note: To respect the time of our other clients, product scans are limited to three (3) products per 30 minute appointment. Any amount higher than three (3) requires an appointment time of no less than 60 minutes.

Cancellation Notice: I understand that Acacia Whole Health has a 24-hour Advance Cancellation Policy. Clients canceling with less than 24 hours notice will be charged the following cancellation fees:

90 minute appointment - $100.00
60 minute appointment - $65.00
30 minute appointment - $45.00

The Practitioners at Acacia Whole Health provide holistic complementary health services in the form of dietary and nutritional guidance, nutritional supplements, homeopathic remedies and use of frequency generators.

As complementary health service providers, Practitioners at Acacia Whole Health are not required to be licensed, certified or registered by the state of Colorado as a health care professional.

Degrees, certifications and affiliations:

Rennetta Nikolic:

- Clayton College of Natural Health; Bachelor of Natural Health Studies; Doctor of Naturopathy
- American Association of Acupuncture and Bio-Energetic Medicine; Level II Certification; Electro-Dermal Screening and Measurement
- Institute of Quantum Medicine, Computronix Electro Medical Systems, National College of Oriental Medicine; Level III Certification; Electro-Dermal Screening and Measurement
- American Naturopathic Medical Association

Stefan Nikolic:

- Nutrition Therapy Institute; Certified Nutrition Therapist
- Zyto Technology; Elite Certification

Casey Docksey:

- Trinity School of Natural Health; Certified Holistic Health Practitioner
- Zyto Technology; Elite Certification

Colorado SB 13-215 requires that we recommend you consult with your primary care physician, obstetrician, gynecologist, oncologist, cardiologist, pediatrician, or other board-certified physician regarding the recommendations made by the Practitioners at Acacia Whole Health.

Practitioners at Acacia Whole Health are covered by liability insurance for the services provided.

I hereby authorize the Practitioners at Acacia Whole Health to act on my behalf concerning the health analysis procedure for energy evaluation, and develop a suggested health program. I warrant that all information presented for analysis and evaluation was submitted by me and is true to the best of my knowledge.

I recognize that the health analysis procedure is an established method that is approved by the Food and Drug Administration to measure galvanic skin response, and is not yet approved by the American Medical Association.

I acknowledge that the health analysis procedure, the evaluation and the suggested health program are not for the diagnosis, treatment, alleviation, mitigation, prevention or care of any disease. With this in mind, I reserve the right to use the knowledge I gain regarding my own body in any legal manner I may choose, including the suggested health program.

I understand that my records are kept strictly confidential, and will only be released upon my written consent.

Please sign that you have read, fully understand and agree to the above terms:

Signature ______________________________ Date ______________

FAMILY MEDICAL HISTORY **(This does not refer to you but your family)**

IF DECEASED, AGE PARENTS DIED: MOTHER_______________ FATHER_____________

PERSONAL MEDICAL HISTORY **(Your medical history)**
You may email us a current document, or fill out the information below.

ALLERGIES **(Drugs, chemicals, foods, animals, seasonal, etc.)**

____

HAVE YOU EVER RECEIVED VACCINATIONS? YES NO

CURRENT VACCINATIONS? YES NO

CURRENT MEDICATIONS, SUPPLEMENTS, HOMEOPATHICS, ETC

MAJOR COMPLAINTS

DATE IT BEGAN BETTER WORSE SAME

HAVE YOU EVER HAD THIS CONDITION BEFORE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS?

IF YES, WHEN? BY WHOM?

WHAT WERE THE RESULTS?

WHAT MAKES IT BETTER?

WHAT MAKES IT WORSE?

RESPIRATORY

CARDIOVASCULAR

PAIN

HAIR

NAILS

EARS

NOSE

EYES

MOUTH/THROAT

SKIN

URINATION (4-6 TIMES PER DAY IS NORMAL)

THIRST

SLEEP

HEADACHES/DIZZINESS

DIGESTION

BOWELS/STOOL

PERSPIRATION

BODY TEMPERATURE

ENERGY

HABITS

SMOKING (AMOUNT): ____________ (cigarettes per day / week)
ALCOHOL: (amount) ____________ (drinks per day / week)
RECREATIONAL DRUGS: (type) ______________________ (amount) ___________ (per day / week)

EXERCISE

APPETITE

WEIGHT

FOR MALES - ARE YOU EXPERIENCING

FOR FEMALES:

ARE YOU OR COULD YOU BE PREGNANT: YES NO

IF YES, APPROXIMATE DATE OF CONCEPTION:

ARE YOU EXPERIENCING:

DO YOU HAVE REGULAR PAP TESTS? YES NO

DATE OF LAST PAP:

MENSTRUAL CYCLE

EXPLAIN ANY OF THE ABOVE:

MENOPAUSAL FEMALES ONLY:

MENOPAUSAL SYMPTOMS

STRESS:

PLEASE LIST ANY PHYSICAL OR EMOTIONAL STRESSORS IN YOUR LIFE:

LIST ANY SIGNIFICANT TRAUMAS (PHYSICAL OR EMOTIONAL) INCLUDING APPROXIMATE DATE:

PLEASE DESCRIBE EMOTIONAL OR BEHAVIORAL PATTERNS ABOUT YOURSELF THAT YOU WOULD LIKE TO CHANGE:

HOW DO YOU COPE WITH STRESS?

DO YOU HAVE A DAILY PRACTICE OF SELF CARE? (I.E. JOURNALING, MEDITATION, PRAYER, DEEP BREATHING, STRETCHING) PLEASE DESCRIBE:

PLEASE RATE YOUR HEALTH ON A SCALE OF 1-10 (10 = BEST, 1=WORST)
PHYSICAL................................MENTAL/EMOTIONAL.......................SPIRITUAL

PLEASE LIST HOW MUCH OF THE FOLLOWING YOU GET PER DAY:

SLEEP (IN HOURS)? ____________________

WATER (IN OUNCES)? __________________

EXERCISE (IN MINUTES)? _______________

REST/RELAXATION/RECREATION (IN MINUTES/HOURS)? _________________________

SUNLIGHT/FRESH AIR/TIME IN NATURE (IN MINUTES/HOURS)? ____________________

NUTRITION:
PLEASE LIST HOW OFTEN YOU CONSUME THE FOLLOWING FOODS:

	DAILY	WEEKLY	1-2X MONTHLY	NEVER
VEGETABLES				
FRUITS				
WHOLE GRAINS				
BEANS/SEEDS/NUTS				
CHICKEN/TURKEY				
FISH/SEAFOOD				
EGGS				
DAIRY (YOGURT/KEFIR)				
DAIRY (CHEESE/MILK)				
ORGANIC FOODS				
PORK/HAM				
RED MEAT				
SWEETENED JUICE				
CAFFEINE				
GLUTEN/BREAD				
SODA (INCLUDING DIET)				
SUGARY FOODS				
SOY				
CORN				
ALCOHOL				
FRIED FOODS				