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

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

OTHER SERVICES (Cost/Session):

Frequency Generator - $59.00
Ion Cleanse - $50.00

**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)
CIRCLE ALL THAT APPLY

CANCER	KIDNEY DISEASE	ULCERS
DIABETES	EPILEPSY	ARTHRITIS
HIGH/LOW BLOOD PRESSURE	ASTHMA	ALCOHOLISM
HEART TROUBLE	LIVER DISEASE	SPINAL PROBLEMS
TUBERCULOSIS	SINUS PROBLEMS	MENTAL DISORDERS
ALLERGIES	LYME DISEASE	DRUG ADDICTIONS

OTHER: _____

IF DECEASED, AGE PARENTS DIED: MOTHER_____ FATHER_____

PERSONAL MEDICAL HISTORY (Your medical history)

MAJOR SURGERIES, ILLNESSES, DISEASES, ACCIDENTS

_____

_____

ALLERGIES (DRUGS, CHEMICALS, FOOD, ANIMALS, SEASONAL, ETC.)

_____

_____

HAVE YOU EVER RECEIVED VACCINATIONS? YES NO

CURRENT VACCINATIONS? YES NO

MEDICATIONS (INCLUDE VITAMINS, HERBS, PRESCRIPTIONS, HOMEOPATHICS AND ALL OVER THE COUNTER PREPARATIONS)

_____

_____

_____

MAJOR COMPLAINT(S)

_____

_____

_____

_____

DATE BEGAN_____ HAS IT GOTTEN: WORSE SAME BETTER DESCRIBE

HOW IT STARTED:

HAVE YOU EVER HAD THIS CONDITION BEFORE?_____

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION?_____

IF YES, WHEN?_____ BY WHOM?_____

WHAT WERE THE RESULTS?_____

WHAT MAKES IT BETTER?_____WORSE?_____

RESPIRATORY

SHORT OF BREATH	DRY COUGH	COUGH/BLOOD
DIFFICULT INHALE	ASTHMA	HARD TO BREATHE LYING DOWN
SIGH A LOT	COUGH/PHLEGM	
CHEST PAIN	BRONCHITIS	NORMAL
DIFFICULT EXHALE	TIGHTNESS IN CHEST	

OTHER: _____

CARDIOVASCULAR

DIAGNOSED HEART PROBLEMS	HIGH BLOOD PRESSURE	ANEMIA
	VARICOSE VEINS	PURPLE PALMS/FINGERS
PALPITATIONS	FACIAL SWELLING	BROKEN BLOOD VESSELS
CHEST PAIN	SLOW HEART BEAT	NUMBNESS IN EXTREMITIES
LOW BLOOD PRESSURE	MURMUR	NORMAL
BLEED EASILY	IRREGULAR HEARTBEAT	
ANKLE SWELLING	HAND SWELLING	

OTHER: _____

PAIN

LOWER BACK	UPPER BACK	BOTHERED BY DAMP WEATHER
SHOULDER	HIPS	
MUSCLE WEAKNESS	MUSCLE SPASM/TWITCH	FOOT/ANKLE
SCIATICA	MID BACK	NERVE PAIN
HANDS/WRIST	KNEES	ARTHRITIS
MUSCLE CRAMPS	NECK/SPINE	FLANK AREA

OTHER: _____

HAIR

DRY OILY DANDRUFF FALLING OUT EARLY GREY NORMAL

NAILS

SOFT	GROW SLOWLY	PURPLE
BREAK EASILY	SPOTTY	GROW FAST
PALE	RIDGES/LINES	NORMAL

OTHER: _____

EARS

POOR HEARING	DISCHARGES	RINGING (LOW PITCH)
RINGING (HIGH PITCH)	EARACHES	NORMAL

OTHER: _____

NOSE

STUFFY NOSE	BLEEDING	BLOW A LOT
HAYFEVER	LOSS OF SMELL	ENVIRONMENTAL SENSITIVITY
SNEEZE A LOT	TMJ	
MUCOUS	RHINITIS	NORMAL

OTHER: _____

EYES

WEAR GLASSES/CONTACTS	YELLOW SCLERA	STRAIN
EYELIDS SWOLLEN	BLINK OFTEN	COLOR BLINDNESS
CATARACTS	POOR NIGHT VISION	BLURRY VISION
SPOTS/LINES IN VISION	FAILING VISION	TEAR EASILY
INFLAMMATION	TWITCHING	REDNESS
GLAUCOMA	SENSITIVE TO LIGHT	ITCHING
PALE UNDER EYELIDS	HISTORY OF STIES	PAIN
DRYNESS	NORMAL	

OTHER: _____

MOUTH/THROAT

DRY	SORES IN MOUTH	DROOLING
GUM PROBLEMS	SORES ON TONGUE	GRIND TEETH
HOARSENESS	DIFFICULTY SWALLOWING	SWOLLEN GLANDS
FREQUENT COLDS	THYROID PROBLEMS	LUMP IN THROAT
TMJ	HICCUPS	TEETH PROBLEMS
SORE THROAT (OFTEN)	DRY/CRACKED LIPS	NORMAL

OTHER: _____

SKIN

DRY	BRUISE EASILY	WARTS
HIVES	BODY ODOR	YELLOW SKIN
CLAMMY	RASHES	ECZEMA
ULCERS	MOLES	BOILS
OILY	CUTS HEAL SLOWLY	NORMAL
PIMPLES	ITCHING	

OTHER: _____

URINATION (3-4 TIMES PER DAY IS NORMAL)

FREQUENT	INCONTINENCE	SCANTY
BURNING	KIDNEY STONES	PAINFUL
URGENCY	PROFUSE	UNUSUAL COLOR
BLADDER INFECTIONS	PUS	NORMAL
NIGHTTIME	STRONG SMELL	
BLOOD	CLOUDY	

OTHER: _____

THIRST

LESS THAN NORMAL	EXCESSIVE	PREFER HOT DRINKS
PREFER COLD DRINKS	THIRSTY BUT DO NOT DRINK	NORMAL

OTHER: _____

SLEEP

HARD TO FALL ASLEEP	HARD TO GO BACK TO SLEEP	TIRED IN THE MORNING
AWAKE EASILY	LOTS OF DREAMS	SLEEP TOO MUCH
RESTLESS	NIGHTMARES	NORMAL

OTHER: _____

HEADACHES/DIZZINESS

HEADACHES	POOR BALANCE	DIZZY IF STANDING/BENDING
VERTIGO	MIGRAINES	NORMAL
DIZZINESS	FAINT EASILY	
MOTION SICKNESS	POOR MEMORY	

OTHER: _____

DIGESTION

INDIGESTION	BELCH	BITTER TASTE
NERVOUS STOMACH	BLOAT	WEIGHT PROBLEMS
FULL FEELING	PAIN/CRAMPS	GREASY FOOD ISSUES
HEARTBURN	GAS	NORMAL
NAUSEA/VOMITING	BAD BREATH	
STOMACH NOISES	GALLSTONES	

OTHER: _____

BOWELS/STOOL

LOOSE STOOL	STOOLS W/ BAD SMELL	HARD STOOL
BLOOD IN STOOL	ANUS ITCH	INTESTINAL WORMS
UNDIGESTED FOOD	BURNING ANUS	SMALL STOOL
DIARRHEA	MUCOUS IN STOOL	PAIN/CRAMPS
HEMORRHOIDS	COLON PROBLEMS	USE LAXATIVES
CONSTIPATION	BLACK STOOL	NORMAL

OTHER: _____

PERSPIRATION

VERY LITTLE	NIGHT SWEATS	FEET
PROFUSE	SWEATY PALMS	WITHOUT EXERTION
EASILY	BAD SMELL	NORMAL

OTHER: _____

BODY TEMPERATURE

WARM NATURED	WARM PALMS	WARM SOLES
FLUSHED FACE	COLD NATURED	COLD HANDS/FEET
WARMER IN PM	CHILLS/FEVER	NORMAL

OTHER: _____

ENERGY

UP AND DOWN	LOW AFTER EATING	EXCESSIVE
LOW	TIRED IN AFTERNOON	NORMAL

OTHER: _____

HABITS

SMOKING (AMOUNT): _____ (cigarettes per day / week)

ALCOHOL: (amount) _____ (drinks per day / week)

RECREATIONAL DRUGS: (type) _____ (amount) _____ (per day / week)

EXERCISE

NEVER LITTLE MODERATE HEAVY

APPETITE

UP & DOWN POOR GOOD HUNGRY LOSS OF TASTE

WEIGHT

NORMAL UNDERWEIGHT OVERWEIGHT RECENT GAIN / LOSS

FOR MALES:

ARE YOU EXPERIENCING:

REDUCED SEX DRIVE	IMPOTENCE	PROSTATE PROBLEMS
PREMATURE EJACULATION	DISCHARGES	PAINFUL URINATION
SEMINAL EMMISSION	GENITAL PAIN	DRIBBLE OF URINE

OTHER: _____

PLEASE EXPLAIN ANY OR ALL OF THE ABOVE: _____

_____

FOR FEMALES:

ARE YOU OR COULD YOU BE PREGNANT: _____

IF YES, APPROXIMATE DATE OF CONCEPTION: _____

ARE YOU EXPERIENCING A REDUCED SEX DRIVE? _____

OTHER DIFFICULTIES? (PLEASE EXPLAIN): _____

_____

DO YOU HAVE REGULAR PAP TESTS? _____ DATE OF LAST PAP TEST: _____

DO YOU HAVE EXCESS FACIAL OR BODY HAIR? _____

MENSTRUAL CYCLE

AGE BEGAN: _____ DAYS OF FLOW: _____ AGE STOPPED: _____

HOW MANY DAYS BETWEEN PERIODS: _____

ARE YOUR PERIODS:

IRREGULAR	RETAIN WATER	SIGH A LOT
PAINFUL	BACKACHE	CONSTIPATION
HEAVY FLOW	BREAST PAIN	DIARRHEA
CLOTTING	BREAST LUMPS	TIGHT CHEST
SCANTY FLOW	SPOTTING IN BETWEEN	HORMONAL PROBLEMS
LIGHT COLOR	ABDOMINAL BLOAT	LUMP IN THROAT
DARK COLOR	EMOTIONAL	NORMAL

EXPLAIN ANY OR ALL OF THE ABOVE: _____

MENOPAUSAL FEMALES ONLY:

HOW MANY YEARS HAVE YOU BEEN MENOPAUSAL: _____

SINCE MENOPAUSE, DO YOU EXPERIENCE:

HOT FLASHES	DEPRESSION	ACNE
MENTAL FOGGINESS	PAINFUL INTERCOURSE	INCREASED VAGINAL PAIN, DRYNESS OR ITCHING
DISINTEREST IN SEX	SHRINKING BREASTS	
MOOD SWINGS	FACIAL HAIR GROWTH	

STRESS:
PLEASE LIST ANY PHYSICAL OR EMOTIONAL STRESSORS/CAUSES OF ANXIETY IN YOUR LIFE:

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

AS BEST YOU CAN, PLEASE DESCRIBE ANY EMOTIONAL ISSUES YOU'RE FACING RIGHT NOW OR PARTICULAR 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 THE FOLLOWING ON A SCALE OF 1-10, WITH 10 = BEST & 1= WORST

	ON A SCALE OF 1 TO 10…
YOUR PHYSICAL HEALTH	
YOUR MENTAL/EMOTIONAL HEALTH	
YOUR SPIRITUAL HEALTH	

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				