NATURALLY NOA

Because real health starts from within

Confidential Health History Form

Full name: _____

Address:

_____

Email address: _____

Cell: _____

Age: _____Height:_____Date of Birth:_____

Place of Birth:_____

Current weight:_____Weight six months ago:_____A year ago:_____

Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____

Children: _____ Pets: _____Grandchildren:_____

Occupation/ main recreational activity : _____

Hours of work per week: _____

Do you have a strong community of friends and/or family around? _____

Please list your main health concerns:

_____

_____

_____

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Other concerns and/or goals?_____

_____

Stress level 1-10 (1 very low stress 10 very high stress) _____

Reason?_____

Current home life (circle): stressful /calm. Explain_____

Childhood home life (circle): stressful/calm. Explain_____

Recent or childhood trauma you wish to share_____

_____

_____

At what point in your life did you feel your best_____

Any serious illnesses/hospitalizations/injuries? When?

_____

Childhood Vaccines? Y/N_____ Which ones?

_____

_____

Vaccines as an adult Y/N_____Which ones? _____

COVID vaccine? Y/N_____ How many? _____ Date of the last one_____

Flu vaccine? Y/N_____ Date of the last one_____

Amalgam fillers? Y/N _____Root Canals? Y/N____How many?_____

High-impact sports such as equestrian, MMA, football, soccer etc.? Y/N?_____ Which one?

_____Falls? Y/N_____ Concussions? Y/N_____

When?_____

Women only IUD? Y/N Birth control pills? Y/N How long?_____

Implants? Y/N C-section Y/N Botox Y/N Date of last injection_____ where_____

Have you been exposed to environmental toxins? (Y/N) If yes, circle all that apply: scented candles, perfume, commercial laundry detergents, household cleaning products, scented plug-ins, mold, radiation (e.g., X-rays), electronic devices, commercial deodorants, fluoride toothpaste, commercial mouthwash, other (please specify)

_____

Did you receive antibiotics at some point in your life? Y/N When? _____

Why?_____ How long were you on them?_____

Scars? Y/N Surgeries? Y/N Date_____

How is/was the health of your mother?

_____

How is/was the health of your father?

_____

What is your ancestry?

_____

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Do you sleep well? _____How many hours? _____ do you wake up at night?

_____Why?_____

Any pain, stiffness or swelling _____

Constipation/Diarrhea/Gas? Please explain:

_____

Allergies or sensitivities? Please explain:

_____

Do you take any supplements or medications? Please list:

_____

_____

Any healers, helpers, or therapies with which you are involved? Please list:

_____

_____

What role does sports and exercise play in your life?

_____

What foods did you eat often as a child?

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Liquids_____

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What's your food like these days?

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Liquids_____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

_____

Percentages of home -cooked food ____Do you cook? Y/N

Where do you get the rest from?

_____

Do you crave sugar, coffee, cigarettes, or have any major addictions?

_____

How much water do you drink per day_____

How many times a day do you poop? _____ Solid / liquid? _____

Easy stool Yes/No? _____

Do you follow a certain diet or restrictions?

_____

What time you finish dinner? _____

What time do you go to sleep? _____

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The most important thing I should change about my diet to improve my health is:

_____

Anything else you want to share? _____

_____

Waiver

I acknowledge that I am aware that Naturally Noa and its members are not medical doctors and do not diagnose disease. I also acknowledge that I have been advised to consult a physician before undergoing any dietary or food supplement changes. I also affirmatively state that I have disclosed any and all known medical or genetic conditions, medications I use, and any significant personal or family medical history. Any recommendations that I follow for changes in diet, including but not limited to the use of food supplements, as well as the use of therapeutic modalities, are entirely my choice and responsibility. I am knowingly assuming any risk associated with them.
In consideration of my participation in this counseling and the use of selected therapeutic modalities, I hereby accept all risk to my health and of my injury or death that may result from such participation, and I hereby release Naturally Noa, its members, officers, agents, employees and independent contractors from any liability whatsoever to me, my personal representatives, estate, heirs, next of

kin, and assigns for any and all claims and causes of action for loss of or damage to my property and for any and all illness, injury or other harm to my person, including my death, that may result from or occur during my participation in nutrition counseling, whether caused by the sole or concurrent negligence of Naturally Noa, its members, officers, agents, employees and independent contractors. I further agree to indemnify and hold harmless the Naturally Noa, its members, officers, agents, employees, and independent contractors, to the fullest extent permitted under law, from any and all liability for the injury or death of any person(s) and property damage that may result from my negligent or intentional act or omission while participating in the described nutrition counseling session.

Please check with your doctor before adding new supplements; this is NOT medical advice.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR MY INJURY OR DEATH OR DAMAGE TO MY PROPERTY THAT OCCURS WHILE PARTICIPATING IN NUTRITION COUNSELING AND OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY MY NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

Name Date

_____ _____