**Intake Data**

**Name** ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth** ­­­­\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telephone (best)** ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for visit (prioritized):**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional data:**

How many ounces of water/day? \_\_\_\_\_\_\_\_\_\_\_\_ What kind? ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What other beverages & how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use artificial sweeteners? \_\_\_\_\_\_\_\_ Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_

Consume alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How much/often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke/vape/inhale substances? \_\_\_\_\_\_\_\_ What? \_\_\_\_\_\_\_\_\_\_\_How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat breakfast? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much of the following do you consume?** (example: 1D = 1/day, 2W = 2/week, 3M = 3/month)

Fresh fruit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Raw vegetables \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fermented foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fast foods \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Meat \_\_\_\_\_\_\_\_\_\_\_\_\_ Eggs \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dairy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you crave? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What foods do you dislike the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience (Y/N): Gas \_\_\_\_\_\_\_\_\_ Bloating \_\_\_\_\_\_\_\_\_ Diarrhea \_\_\_\_\_\_\_\_\_ Indigestion \_\_\_\_\_\_\_\_\_\_

Do you regularly take your blood pressure? \_\_\_\_\_\_\_\_\_ What is it generally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly take your blood sugar levels? ­­­­\_\_\_\_\_\_\_\_What is it generally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Timing:**

What is the first thing you do when you get up in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you eat your first meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which meal is your largest of the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe a typical largest meal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Movement:**

Do you exercise/move/participate in fun sweaty activity? \_\_\_\_\_\_\_\_\_\_\_\_ If so, what and how often?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you look forward to it? \_\_\_\_\_\_\_\_\_\_How do you feel when you are finished? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:**

What time do you go to bed? ­­­­­\_\_\_\_\_\_\_\_ How long do you sleep? \_\_\_\_\_\_\_\_Do you wake often? \_\_\_\_\_\_\_\_\_

If so, why and what time(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel rested when you wake up for the day? \_\_\_\_\_\_\_\_\_\_\_\_

Do you have pain when you first get up? \_\_\_\_\_\_\_\_\_\_\_ If so, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it go away upon moving? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eliminations:**

Do you have daily bowel eliminations? \_\_\_\_\_\_\_\_\_\_\_\_ If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please describe your elimination pattern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the most descriptive number(s) of your elimination(s) using the Bristol Stool chart

Provided on page 6 of this form. BSC # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feel that your bladder empties completely? \_\_\_\_\_\_\_ Difficulty/strain to get urine flow started? \_\_\_\_\_\_\_\_\_

Need to urinate suddenly/without build up? \_\_\_\_\_\_\_ Problems starting/stopping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What color is your urine generally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotional Health:**

How would you describe your general outlook on life? ­\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On scale of 1-10 (on average day) how stressed do you feel? (1 not at all … 10 extremely) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you felt this way? ­­­­­­­­\_\_\_\_\_\_\_\_ Has this changed recently? \_\_\_\_\_\_\_\_ Better/Worse? ­­\_\_\_\_\_\_\_\_\_

**Females:**

Are you post-menopausal? \_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, at what age did you enter menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_

What were the characteristics of your menopausal experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use Hormone Replacement (HRT) or Hormonally-based Contraception? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you now, or in the near future, planning to become pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your menstrual cycle regular? \_\_\_\_\_\_\_\_\_\_ Longer than 28 days? \_\_\_\_\_\_\_\_\_\_\_ Shorter? \_\_\_\_\_\_\_\_\_\_\_\_

Is your flow longer or shorter than 5 days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have cramps or clotting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Would you describe the color of your menses as

bright red, dark purple or brown? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience PMS, cyclical headaches or cravings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supplements/medications:**

Do you take any supplements? \_\_\_\_\_\_\_\_\_\_\_\_\_ If so, what, how often and why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you take any OTC medications routinely (such as: pain reliever or allergy medicine)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you take prescription medications (prescribed by a licensed medical professional)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so, what and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical history:**

Have you had any surgeries? \_\_\_\_\_\_\_\_\_ If so, what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you received any diagnoses from licensed medical professionals? If so, what and when? \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What vaccines have you received? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Naturopathic history:**

Have you ever been in consultation with a naturopath? \_\_\_\_\_\_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was suggested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you experience a good outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you like about it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What wasn’t as successful for you? ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have regular adjustments with a chiropractor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have regular body work/massages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What natural modalities have you experienced? ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What natural modalities do you currently use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all with which you are familiar:

* Homeopathy
* Bach Flowers/flower remedies
* Probiotics
* Aromatherapy
* Muscle response testing
* Herbals
* Sports nutrition
* Enzymes

**Please provide the following at your appointment time:**

\* 7-day food journal of what you have eaten daily

\* this intake form-completed before appointment

I understand that I am here to learn about nutrition and better health practices, 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 purpose 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 on nutritional matters intended for the maintenance of the best possible state of natural health and do not involve diagnosing, treatment or prescribing of remedies for disease.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Disclaimer:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am a Board-Certified Doctor of Natural Medicine.

I am not a medical doctor and do not prescribe medications.

I recommend natural, holistic supplementation and modalities.

As a client of Denise Lambert Cassano or Essential FARMacy, LLC, I understand that Denise Lambert Cassano or anyone acting on behalf of Essential FARMacy, LLC may provide suggestions and other health-related information, based on their holistic training, knowledge, experiences and understanding to help me attain my personal best health.

All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health and nutritional habits.

I understand that Denise Lambert Cassano and anyone acting on behalf of Essential FARMacy, LLC, do NOT ever attempt to diagnose, treat, cure or claim to cure cancer, sickness or any other disease.

I understand that Denise Lambert Cassano or anyone acting on behalf of Essential FARMacy, LLC, addresses the total health of the person and that this is a personal ministry and spiritual counseling.

I understand and agree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (initials)

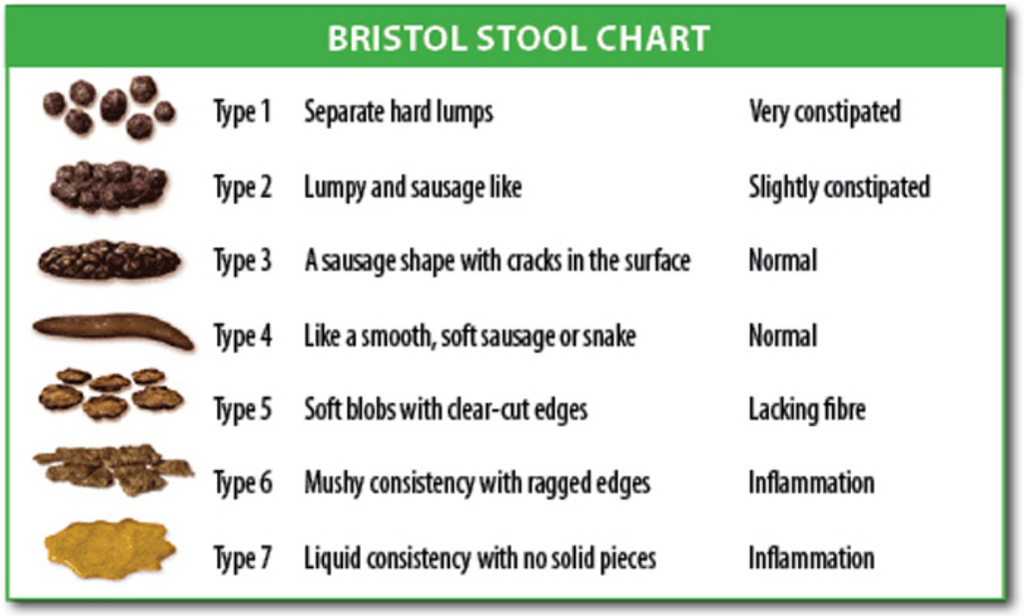
Client Signature:

Denise Lambert Cassano,

BCDNM, CNM, CHHP, BS Pharmacy

Essential FARMacy, LLC

864-559-8811



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|  | GETTING TO KNOW YOU…  Before your Zyto scan! | | | | | | | | | | | | | | | | | | | | | | | |
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| *Welcome…please fill out this form to the best of your ability. If you get stuck, don't worry…we will review this form together. We will utilize this information in your consultation. Relax…you are in the right place.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **Name:** | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Today's Date:** | | | | |  |  |  |  |  |  |
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|  | **Address:** | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Birthdate:** | | | | |  |  |  |  |  |  |
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|  | **Phone:** | | |  |  |  |  |  |  |  |  |  |  |  |  | **Email:** | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **Occupation:** | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **How did you find us?** | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| INFORMED CONSENT | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| We apologize in advance for the legal jargon which follows. We live in a crazy time, where the pressure of government, economic, and legal agencies weigh heavily on those working to provide quality, natural healthcare. Please read the informed consent below and sign to acknowledge your understanding. If you have any questions, please feel free to ask! | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I acknowledge that Denise Cassano and anyone acting on behalf of Essential FARMacy, LLC, are not medical doctors. I understand that Denise Cassano and anyone acting on behalf of Essential FARMacy, LLC, may provide nutritional and other health-related information, based on their knowledge, experiences, and understanding, to help me attain my personal best health. All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health habits, and advanced nutrition. I understand that Denise Cassano and anyone acting on behalf of Essential FARMacy, LLC, do NOT ever attempt to diagnose, treat, cure, or claim to cure cancer, sickness, or any other disease. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I have read this informed consent, and I understand it. I am not a minor. (If scanning for someone under the age of 18, please give parental signature below.) Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for any federal, state, or local agencies on a mission of entrapment or investigation, and I also certify that I am signing my own true given, legal name and not an alias or false name. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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## AN UNDERSTANDING OF SERVICES

* I fully understand that you are not diagnosing or treating for any disease or health care condition. I fully understand that if I have any disease or health condition, I must seek qualified medical advice from a licensed physician.
* I fully understand that my interest is in learning to plan and follow a good nutritional program. I am interested in learning ways to help develop and maintain better health.
* I fully understand that recommendations, suggestions, and references to meals, menus or nutritional supplements are for general health maintenance and do not involve any diagnosing or prescribing for the treatment of any disease or health condition.
* I fully understand that you are dedicated to educating your clients to help themselves to better health with emphasis on education and self-care. I understand that what you teach may not be universally accepted and agencies or other health authorities may not agree with this approach where clients must be responsible for developing and maintaining their own health.
* I hereby certify that I am not an employee, agent, or otherwise affiliated with the Federal Food and Drug Administration or an affiliated agency. I further understand: According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term “Drug” is designed to mean: Articles intended for use in diagnosis, cure, mitigation, treatment or prevention of disease. In other words, to “say” that a vitamin, mineral, or other food supplement will have any effect on disease symptoms thereof, that particular nutrient then becomes a drug under the law as written. Therefore, any suggested nutrition is not intended as a primary therapy for any disease or symptom but is an added schedule of food supplementation provided solely to upgrade and enhance the quality of food delivered through the diet.
* I fully understand that **Nutritional Live Blood Assessment is intended for educational and nutritional information only and is not to be considered medical advice**.
* I give my permission for you to obtain a drop of blood from my fingertip for use in examining my blood under the microscope. I further agree to hold you harmless and release you from any liability in obtaining this sample of blood using a sterile lancet and lancing device commonly used in blood glucose testing. I also understand this test will be conducted using the proper procedure for obtaining and disposal of blood, slides, lancets, alcohol swabs, tissue, cotton, and any other items necessary in sharps containers; as well as gloves and apparel will also be used to help prevent contamination of sample.
* I understand that any photographs of my blood taken by below signed practitioner belongs to them, to use at their discretion, including research. I also understand that my pertinent health information and name will not be used in conjunction with the same and will remain private.

I have read and understand what is written above.

Date:

Signature

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Print Name Email

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